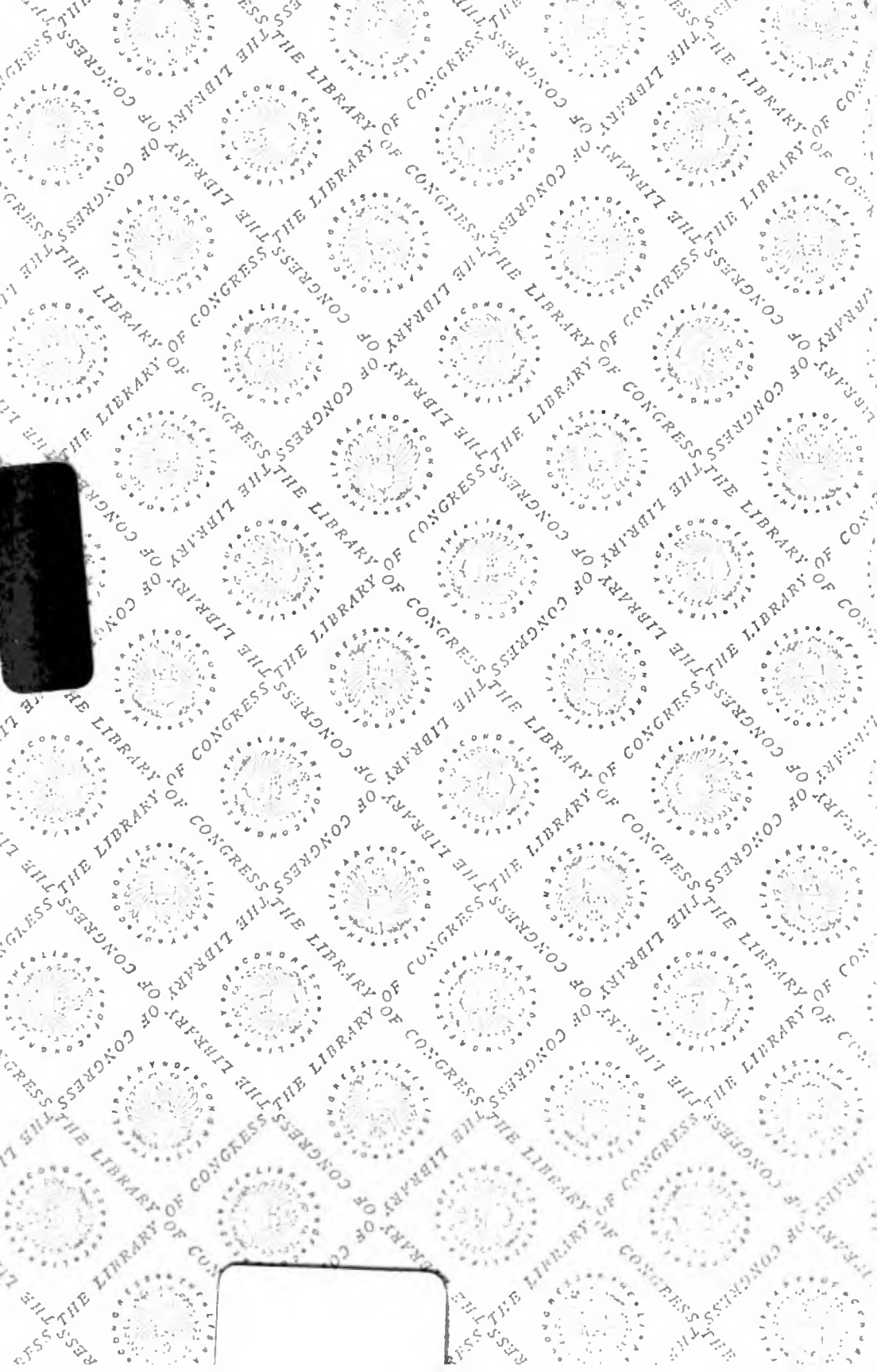

United States. Congress. House. Committee on Interstate and Foreign Commerce. Subcommittee on Public Health and Environment.

REORGANIZATION OF HEALTH PROGRAMS IN HEW

HEARINGS

BEFORE THE

SUBCOMMITTEE ON PUBLIC HEALTH AND ENVIRONMENT

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

HOUSE OF REPRESENTATIVES

NINETY-THIRD CONGRESS

FIRST SESSION

ON

OVERSIGHT ON THE REORGANIZATION OF HEALTH PROGRAMS WITHIN THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

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REORGANIZATION OF HEALTH PROGRAMS IN HEW

MONDAY, JULY 30, 1973

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLIC HEALTH AND ENVIRONMENT,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to notice, in room 2322, Rayburn House Office Building, Hon. Paul G. Rogers, chairman, presiding.

Mr. ROGERS. The subcommittee will come to order.

This morning the subcommittee is conducting oversight hearings on the recent reorganization of the Department of Health, Education, and Welfare.

The Department of Health, Education, and Welfare derives its authority to operate programs from the Congress, and thus it is accountable to the Congress for the performance of its programs. The reorganization of the "H" portion of HEW is thus of great interest to this subcommittee, which has written much of the health program authority for HEW. Today's hearing will focus on the effect of the reorganization on the programs developed by this subcommittee, as well as its effect on the maternal and child health programs.

This subcommittee has nothing against reorganization. Indeed, few would argue that HEW does not need a reorganization in the health field. However, if the effect of the reorganization is to retard programs developed by this subcommittee, then we will consider legislative action to reverse decisions which retard the proper functioning of those programs.

We will be hearing testimony on this from Dr. Charles Edwards, Assistant Secretary for Health of the Department of Health, Education, and Welfare. Our first witness this morning, is the Honorable Hugh Carey, a member of the House Ways and Means Committee.

Before we have witnesses today I think Dr. Roy, as I understand, may have some remarks he would like to make before we get into witnesses and the Chair would recognize the gentleman.

Mr. ROY. Thank you, Mr. Chairman.

I very much appreciate the fact that today we are going to have hearings on the reorganization of the Health Division of the Department of Health, Education, and Welfare. Mr. Chairman, these hearings are held, as you so well expressed, on national TV this morning at a difficult time in the history of Federal health programs. At the present time programs designed by the Congress to meet the health needs of the people of this Nation are under unprecedented attack. While the officials of this administration pay lip service to and hold propaganda conferences about the importance of Federal programs

designed to improve the health and health care of the people of this Nation, their performance has been diametrically opposed to that position. If we follow John Mitchell's admonition to "watch what we do, not what we say," hardly a worse situation could be imagined——

Mr. CARTER. Mr. Chairman.

Mr. ROY. Within the past year this administration has twice vetoed Department of HEW appropriation bills carefully worked out within the Congress to provide adequate, but not extravagant, funds for health and educational programs. The administration has submitted a budget request for fiscal year 1974 for health programs which, if we include inflation, provide 16 percent less funds for health programs than was appropriated in fiscal year 1972. And perhaps most serious of all, this administration has illegally impounded—or at least left unspent—$1.1 billion of health funds in 1973. It should be stressed that this attack is not merely an attack on Federal health programs, but it is also an attack on the Congress and the very constitutional basis for our Government. The funds impounded—or as I said, at least not spent—in fiscal year 1973 were legally authorized and appropriated and according to the provisions of section 601 of the Public Health Service Act, which was adopted by an override of a Presidential veto in 1970, funds appropriated pursuant to the Public Health Service Act must be spent. The impoundment or nonspending of health funds in fiscal year 1973 is a clear example of the administration's considering itself above the law.

Subsequent to this unprecedented attack on both Federal health programs and the constitutional powers of Congress, the Department of Health, Education, and Welfare began a reorganization of the administration of health programs in February of this year. This reorganization was from the beginning unmistakenly a part of the attempt to reduce and abolish a number of health programs.

The first line of the charge to the committee on the reorganization states, "The administration has made a number of policy decisions on the direction of Federal programs for health services."

This reorganization is then unmistakenly a political reorganization. A political reorganization is without basis in legislation, either authorizing or appropriations legislation, a political reorganization whose basis, "administration policy decisions," has been, in fact, explicitly rejected with the passage of Senate 1136 and House Joint Resolution 636 by both the authorizing and Appropriation Committees of the House and Senate of the United States.

In recent days we have heard much from this administration about this administration's illegal activities and subsequent attempts to cover up certain activities. We have heard about burglaries and subsequent payoffs to the burglars. We have heard about illegal bombing raids and subsequent falsification of reports, so in health we know well of the illegal impoundment of $1.1 billion in fiscal year 1973 moneys. Today we prepare to hear testimony on an attempt to cover up the impoundment by the so-called reorganization of the health division of the Department of Health, Education, and Welfare.

Thank you, Mr. Chairman.

Mr. ROGERS. Dr. Carter, you may say something.

Mr. CARTER. Mr. Chairman, I do wish to say something. I am distressed to see this committee, which has been organized to legislate

on health and environment, sink to the lowest depths of politics. I regret it very much. As every man on this committee knows, and as Dr. Edwards and his staff know, I have supported every worthwhile piece of health legislation for the past 8½ years, and have opposed all cuts in appropriations.

It is with extreme regret that I see this committee made a political forum to launch the campaign of the gentleman for the Senate in Kansas. I regret this. I had hoped that we wouldn't sink to politics on this committee.

Now, Mr. Chairman, if we want to do some reorganization, and this Committee has suggested that we do that, I want to remind you that there is a bill before you which would establish legislation providing funds for different diseases for research, treatment, and so on, for different diseases according to the mortality, morbidity, and economic impact of such diseases. For instance, since heart disease has the greatest mortality, morbidity, and economic impact in our country, then most of our funds should be devoted in this area. Second, since the cancer is the second greatest killer, then the second amount of funds should be devoted to research and treatment in this area.

This bill which has been introduced before this House for the past 2 years has not been given a great deal of consideration. Instead of that this committee has time after time taken up little bills which have political impact, such as Cooley's anemia. I am a physician, and of many years, but I have never even seen a case of Cooley's anemia. It is a very rare bird.

If the legislation which I had proposed basing appropriations on authorizations on morbidity, mortality, and economic impact, had been in effect it would have been unnecessary to have had a hearing on diabetes last week because it would have received the funds which were necessary for it.

This is not done. Instead of that this committee has chosen to take a political attitude and even insinuate that it would ask for the resignation of one of the most capable Secretaries of HEW we have ever had, Mr. Caspar Weinberger.

I regret that in some cases perhaps funds have been impounded, but I want to tell you that in many others it has been necessary. In mental health, in particular—and I am one of the men who have developed that bill.

In fact, every piece of health legislation which has been enacted in the past 8½ years I have been part of. But we have seen mental health. I have checked it thoroughly, and I have investigated the State of Kentucky. The Executive Secretary, Mr. Asher Tulles, called on me and told me that administration should be cut at least 50 percent. Mr. Weinberger has seen fit to cut in this area, and the reason, the basis of Mr. Tulles' recommendation, was the fact that too much was being spent on administration in this area.

Now the services, the part in which people are helped, was not to be cut. I will give you a specific instance. In one area in Kentucky the regional director was found to have embezzled $6,000 or $8,000, and only left an I O U in his desk. This man had been guilty before of taking funds, and before this time the regional board, as the record shows, had increased his salary so that he could pay back that money.

In Louisville, Ky., we have what is called a crisis center under mental health, and hundreds of thousands of dollars are spent each year on this crisis center. Not a physician is present, but as many as 10 of 15 people are in this crisis center, and when a man who is a potential suicide comes there, the answer given as to his treatment is that they "rap" with him. I think that this is absolutely and totally not the proper treatment. He should see a psychiatrist immediately and be treated by a psychiatrist.

In Lexington, Ky., we had the very same, or something of the same nature happen. Judge Monihan, the Federal judge in that district, told the district attorney, Mr. Eugene Siler, to get to the depths of the dirty treatment and the dirty methods of treatment that were going on in the Lexington unit. This is a matter of record today in the Federal Court of Eastern District of Kentucky.

So I wish to commend the Secretary of HEW for his grit in doing something about the waste of money in mental health. That is being done, and I think is eminently justified. We want to give every cent that is needed in all these areas, and to say that these things are illegal, absolutely illegal, is to say that Thomas Jefferson also violated the law because we know that he began impounding funds during his administration.

I think I came here today not realizing that we would have a political forum on which to impeach members of the party or in which to say all manner of evil against the Secretary of HEW and others. I can't do that. I deeply regret to see this committee, which has done so much for health in the past few years, sink to a low level, and I thank the distinguished chairman for yielding.

Mr. Roy. Mr. Chairman, may I have a word, please?

I made two accusations: No. 1, that funds have been illegally not spent. Like I say, I don't want to use the word "impounded" because it has certain technical meanings. I base that in part on the President's veto message, and the third paragraph of that states the following: "One of the most unacceptable provisions of this bill is in section 601. Here the Congress insists that funds appropriated for any fiscal year through 1973 to carry out the programs involved must be spent." The veto was overridden.

I think the President has stated this very clearly, has admitted that which was provided in that bill. And here, of course, we have a list that is public knowledge. Everyone knows that there has been $1,095 million that have not been spent on these programs.

Now, the second charge I made was that the reorganization is a coverup of the failure to make a health effort within the administration, and I would like to go to page 20 of the study perspective and one of the major items in caps, underlined, is "The new organization must provide for the phaseout of major health service activities." I submit to my friend, Dr. Carter, whom I respect greatly, and who has done an exceptional job in health, that we have not at this time authorized the phaseout of major health service activities.

Now, I am privileged to sit on this committee, and I am very open to consideration of restructuring of our health programs, and phasing out some programs and bringing others together, but I would submit to you that as we study this reorganization, which I have over the past 2 or 3 weeks, we'll see that by administrating a fiat they intend to do

that which they are not authorized to do by law, and I object very strenuously to this.

I think we are seeing the Office of Management and Budget, from whence our Secretary of HEW came, and our Secretary of HEW behave as if this committee and the Congress do not in fact exist, and I feel that I would not be fulfilling my constitutional duty or responsibilities to the people that I represent or to this committee if I didn't object to such highhanded means of doing business.

Mr. CARTER. Mr. Chairman.

Mr. ROGERS. Yes.

Mr. CARTER. In answer to the first allegation, the impoundment of funds, since we know it has gone on since the time of Thomas Jefferson, that is the answer to the first allegation.

Mr. ROY. Will the gentleman yield?

Mr. CARTER. No; I will not yield at this time.

Second, if this committee and the House of Representatives had acted responsibly, impoundment of funds in many areas would not have become necessary. If legislation which had been before you had been passed, such impoundment would not have been necessary.

Mr. ROY. Mr. Chairman, may I have one final word, sir, and that is some legislation provides for the optional spending of funds, and other legislation states specifically that funds must be spent. I think we must differentiate in this respect.

I appreciate your indulgence, Mr. Chairman.

Mr. ROGERS. Now I think we have gotten some things off our chest——

Mr. HASTINGS. Mr. Chairman, may I have a word?

I have listened with a great deal of interest to both you, Mr. Chairman, and to the gentlemen from Kansas and Kentucky. I am highly disturbed, frankly, that if the gentleman from Kansas is correct he is bringing Watergate into the subject of reorganization that we are talking about this morning. If that is so, as I understand the gentleman, then this appears to be what amounts to a trial now of HEW and the Secretary, and the methods by which—and I might say I bow to nobody in opposing HEW when I think they are wrong, and I think HEW might tell you that, but certainly I am not going to participate in what looks to me like it is going to be a trial of Health, Education, and Welfare when in fact I feel our responsibility is a legislative one, and I for one don't intend to participate in what I think at this point to be a trial, a followup of Watergate, which certainly I don't support, and I don't think anybody on this committee does, but I think it is highly improper to inject it into this, and I for one do not intend to stay and participate in this.

Mr. ROY. Mr. Chairman, I would be happy, if the committee approves, to strike the paragraph that made reference to the bombing and burglaries from the record and apologize to the gentlemen for bringing that portion into the record. I think you are correct in that respect.

Mr. CARTER. Mr. Chairman, I have only one thing to say. Even though I come from one of the strongest Republican districts in the United States, I was not associated with the Committee To Re-elect the President of the United States. For some reason they chose not

to run with many of us people in the South. I know nothing of Watergate. Neither does any Member of the Republican Congress, so far as I know. We were not associated with it, and I don't like the allegation of anyone that I had anything, or any other Republican Member of Congress, had anything to do with it, or knew anything about it.

Thank you.

Mr. ROGERS. Well, I am sure that is true.

All right.

Our first witness this morning is our distinguished colleague, the Honorable Hugh L. Carey, who has been a Member of the Congress for many years, who is most active in the health field, and who is on a most important committee that deals with health.

We welcome you to this committee. As I understand that you would like your full statement to be made a part of the record, and without objection it is so ordered.

STATEMENT OF HON. HUGH L. CAREY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. CAREY. That is correct, Mr. Chairman. [See p. 12.]

I have in the hands of the subcommittee a written statement, what I might consider my statement in chief, detailing my reservations and concerns on the present progress of reorganization and the plans of the administration of the health field, and then an oral presentation which I will summarize, I hope, in order to pinpoint and detail and personalize those concerns.

Mr. ROGERS. That will be fine.

Mr. CAREY. Mr. Chairman, may I say that I hope I will not add to any note of acrimony or partisanship in the testimony I shall give, but being a Brooklynite of Celtic origin, I do not feel at all ill at ease or frankly out of sorts being here this morning. I only wish that my colleague from New York, Mr. Hastings, had not found it necessary to leave the subcommittee or that Dr. Tim Lee Carter, my distinguished colleague and old friend, had not done so, because in my opening I did want to pay my sincere homage and respect to both men for the magnificent job they have done in the great tradition of this subcommittee in pursuing progress in the health field.

Mr. ROGERS. The Chair will make those feelings known to the gentlemen when they return.

Mr. CAREY. Mr. Chairman, I may further state that I do appreciate the viewpoint of our colleague, Congressman Roy, and your own to be not a kind of partisanship to that we normally find between the parties or political partisanship but part of the long tradition of a congressional partisanship for progress against the several administrations during which I have served when Congress has had consistently to override and overrule the budget people downtown.

That happened in the Kennedy administration, it happened in the Johnson administration, it is happening in this administration. Somehow and for some reason it appears that when we get around to the theme of a bald budget we find the soft programs to be those which are most delectable to the OMB. I don't know why health has to be classified among the soft programs because it creates the greatest hardships in this country when it is lacking.

That is why I am here this morning, Mr. Chairman. I am here as a member of the Ways and Means Committee. Our function is budget oversight, the revenue side of the budget and the fiscal management necessary to move this country forward. And I came over to this distinguished subcommittee because I have a fear as well as a concern that as we approach and try to prepare for a national health program of any kind, whether it be the Medi-credit plan or any of the other programs now being suggested or the administration program before our committee, my fear, my apprehension, is that it will be beyond our reach in terms of expense. I am practical in terms of implementation, because there cannot be a national program of health delivery service in the comprehensive field unless we have leadership from the top working through the States, so that we have the structure on which to build the health care delivery services.

So my major thrust today before this distinguished subcommittee, Mr. Chairman, is that I see, as a Ways and Means member, that we are in the process of sorting, trying to build a craft, a seaworthy craft, to move ahead in the field of health and we will have little success in doing that if while we are trying to build a seaworthy craft in the field of health someone is out there mining the channel ahead of us so it is going to founder or blow up as soon as it hits the first wave.

That is exactly what I see happening. I am well convinced that any move in terms of the most modest program of health care insurance must be preceded by adequate preventive care, research, and setting up the States in such fashion as we have peer review and health maintenance organizations which will make certain that we don't repeat the mistakes that were unfortunately suffered when we passed medicaid and medicare without such a structure to guard and monitor the expenditures, so that is why I am here this morning.

My concern is with this so-called reorganization. Let me sound a personal note, Mr. Chairman. I know what access to an outstanding medical system means to a family. In January of this year, following 2½ years after radical mastectomy, my wife, Helen Carey, underwent further surgery for cancer. For the last 7 months we have been going to the National Institutes of Health and other centers in the country and in consultation with our private medical persons, and I can say that first hand I have seen the zeal, the expertise, the dedication that this world center at NIH gives to people in need, and I speak from a personal viewpoint with what I hope is a great deal of passion which is understandable.

My wife, the mother of our 14 children, has been saved at this stage from terminal cancer. Why? Because there were available the full range of programs, expert surgery, cobalt techniques, radiology, the careful following of the progress of the disease, and then chemotherapy which has taken hold, but I feel a sense of guilt, if you will, or a sense of greater responsibility that while I am the beneficiary of these, as is my wife, of these new found and great techniques in medicine, what of all those who do not have access to the National Heart and Lung Institute, who do not have access to the maternal and child health care programs, who do not have access to the other great and wondrous developments that can be had if we will keep the progress going at the national level.

So that is why I am here today. I am here in the tradition of great members of this committee, yours, Mr. Hastings, Dr. Carter, Dr.

Roy, and men whose names are legion in medicine like Fogarty, Lister Hill, and Mel Laird.

I think what we are trying to do together, in Ways and Means and your committee, is to build a viable health care structure. For decades the Congress has worked to guarantee every American the right to adequate preventive care and medical treatment. Well, I accuse Mr. Weinberger and his associates, of planning fiscal starvation and bureaucratic euthanasia on the health care programs the Congress has funded to serve that right.

Congressman Fogarty, when chairman of the Labor-HEW Appropriations Subcommittee, took the floor in the mid 1960's and in a series of 60 or so roll calls, placed the House of Representatives squarely in the lead of the health-care movement in this country. He overrode objections of two Presidents of his own party in asserting congressional leadership in the health field. Both he and the ranking minority member of the subcommittee, Mr. Laird, expressed their concern that the White House should leave legislation on health to the Congress. Once the President and Secretary of HEW present their thinking on how our spending priorities should be ordered, they should devote their efforts to a faithful execution and administration of programs passed by the Congress. Mr. Chairman, we are now faced with a carefully connived plan within the White House, OMB and HEW to take this Nation's health-care philosophy and practice back to the day's of President Pierce, who in 1854, vetoed legislation to help the insane as being constitutionally inappropriate.

We are facing an effort on the part of Mr. Weinberger, and his fellow hatchetmen, to wipe out the Federal commitment to Health, Education and Welfare that was supported to strongly back in 1953 by Senator Robert Taft. The distinguished Republican leader of the Senate during President Eisenhower's first term, in commenting on elevating HEW to cabinet status, stated:

> I am very much pleased that we have finally reached our objective. These activities of the Federal Government are tremendoulsy important to the welfare of the Nation.

Senator Taft was joined by Senator Humphrey, who echoed his Republican colleagues sentiments.

Mr. Chairman, I think Mr. Weinberger is showing greater temerity than wisdom, in trying to destroy something that brought Hubert Humphrey and Robert Taft into such unaccustomed harmony.

We are now seeing, instead of a renewal of Republican leadership in this vital area of our national life, a calculated and ruthless attempt to give to the Nation what Weinberger helped Reagan give to California—a philosophy of no-care backed up by a program of no-care.

Mr. Chairman, I believe the American people deserve better than the intermittent care of Medi-Cal. Despite what Weinberger and Reagan think, people need more than sunshine to get and stay well. The people of New England, New York, Florida and the rest of the Nation need and expect a national health care system.

But not only does Mr. Weinberger refuse to present administration proposals on national health care and insurance, he is setting about dismantling the struggling health-care system we now have—a system that took decades for the Congress to build.

The thinking at the White House and HEW is the same. The scorn and arrogance of inhabitants of both, toward the Congress, is bringing a massive clash of these two branches ever closer.

We in the Committee on Ways and Means are presently considering many different proposals for a national health care insurance program. We are weighing proposals such as the Kennedy-Griffiths plan, Medi-credit, Ameri-plan, and others. However, passage of whatever plan we devise will be an empty gesture if Weinberger has already destroyed the research, education, and health care delivery systems vital to the successful operation of such a plan.

Mr. Chairman, the American people are waiting for and expecting such a plan and program. In my own district we have a neighborhood health center, serving over 22,000 people. Real economies are being achieved by this type of program as well as by health maintenance organizations which were operating successfully before Weinberger, with no justifications, returned them to the category of uncertain experiments. Medical care is the top item in the Nixon inflation spiral. But Weinberger is dragging HEW's feet in moving ahead with programs like MIC's and HMO's that will cut the Nation's health care bill.

We all know the necrology of hopes and programs that Mr. Weinberger, hatchetman of HEW, has begun. In this past year HEW failed to spend $1.1 billion, or about 25 percent of all funds appropriated by Congress for health programs, other than medicaid and medicare.

I might insert here, if I might, something by way of an anecdote. It is not apocryphal. It happened over the past weekend. My wife was recovering from a dosage of chemotherapy and my 18-year-old boy had come down with a viral fever, so I administered medication on my own initiative. I was seated before the television relaxing with a glass of wine when I discovered that the labrador had developed pancreatitis, of all of the people in the family. It was midnight and the only one home happened to be the veterinarian. He came and saved the dog. So I hope medicine isn't going to the dogs in this country. I know it is not, but that is a personal experience. We know I think what is going to happen if we let this Secretary or any Secretary tell Congress what to do with the, if you will, systematic planning of health care which has characterized congressional programs.

The Washington Post of this past Saturday, in a front-page story by Stuart Auerbach, puts the lie to this administration's commitment to a war on cancer—a commitment launched with so much fanfare—designed to be a smokescreen for what was really being planned all across the medical research and health-care board.

According to Dr. Rauscher, Nixon-appointed director of the war on cancer, the cutting back in funds for cancer research will result in slowing the time in which effective chemical therapeutic agents will get from the research lab to the patients' bedside. Not only will the war on cancer not get the $640 million it was promised earlier, but funding for the last fiscal year was cut by $59.9 million. The plan for this much heralded war, announced back in 1971, has not even been prepared and sent to the Congress for action.

Other programs have and will fare no better, unless we in the Congress do something about it and do it soon. The National Heart

and Lung Institute was given $44.2 million less than the Congress said it should get. The National Institute of Mental Health was forbidden to spend $199.2 million appropriated by Congress. Medical training was cut by $189 million. Nurse training, cut another $69.7 million. Hospital construction and improvement was funded at $195.2 million; they got not a penny of that amount.

Another area in which HEW is flouting the law is the present spending policy in areas not yet covered by an appropriation. The continuing resolution states that agencies may spend either at the old appropriations level or the lower of the two previous authorizations figures. However, the administration is again in violation of the law, and in numerous areas is spending at the level of the lowest of the new authorization figures. This is against the law and steps should be taken by the Congress to bring this to a halt.

Mr. Chairman, the figures for fiscal 1974 and beyond are even more depressing, particularly when you realize some budget figures include transfers from other agencies and funding authorized in previous years.

The National Academy of Sciences has recently analyzed the Nixon-Weinberger nonbudget for health. While the Academy draws no shocking conclusions from the data they present, there is no need for such statements. The facts speak for themselves.

For all health programs under HEW, excepting Medicare and Medicaid, the National Academy on page 26 of its report concludes, "Thus the net real increase between 1973 and 1974 is $71 million. This increase is not great enough to sustain existing programs at current levels." And we all know what current levels are—they are $1.1 billion less than the Congress said they should be in laws passed by us and signed by the President. I can't help wondering what the combination of billion-dollar impoundments, plus another year of 8-percent inflation will do to the little over $4 billion requested by the President for health. Back in the sixties a rule of thumb was that health programs, particularly those involved in research, needed approximately a 15-percent increase just to continue operating at the same level. I hardly think this punitive $71 million increase, minus a billion or so, will permit much progress on the health research and medical treatment fronts.

Mr. Chairman, the assault on health care by cutting spending and personnel is now full blown. The next step, by the administration, is to attack administratively and destroy the effectiveness of various programs from within their structure. Quite frankly, the analogy between what is happening here, and the process by which cancer attacks the human organism, is too strong to ignore.

A recent press story, which is part of my full statement, quoted Dr. Arthur Lesser, a 32-year veteran in the health care field, and former Director of the Maternal and Child Health Care program. Dr. Lesser, in a statement announcing his protest resignation, declared, "This is the first step in the elimination of categorical programs. It is another disregard for the intent of Congress."

This story, plus information secured from highly respected health care professionals, both in and out of Government, prompted my immediate interest in the proposed reorganization at HEW. These gentlemen confirmed what Dr. Lesser had stated in his announcement of resignation. This reorganization was designed to strip various categories

of support personnel. Leaving the upgraded Assistant Bureau Directors in charge of these downgraded programs, with only five or six apologists, would effectively kill the programs they were proposing to make more efficient.

As an expression of increasing congressional concern over the obvious ill effects on the categorical programs affected within the Bureau of Community Health, 34 of my House colleagues joined with me in writing Secretary Weinberger. We stated that it is our belief that this reorganization is not aimed at increasing efficiency, but is, as Dr. Lesser stated, "another disregard for the intent of Congress."

We asked if the Department plans to discuss this with the Congress, or, at least, ask informal approval of the plan. We requested clarification of how HEW expects transferred program people to service programs to which they were attached by statute. We also asked how the Department plans to move in light of the recent project-funding extension of title V maternal and child health care programs.

Mr. Chairman, it is my firm belief that Congress is beginning to realize that if we are going to achieve anything in dealing with this administration we must actively assert our leadership. Instead of waiting months, as is the case with the recently proposed plan for heart and lung research and treatment, we should demand that the executive meet deadlines contained in the law or congressional requests.

A special in the Sunday New York Times by Harold Schmeck discussed the administration's plan for heart and lung disease. This plan, required by law, unbelievably, was disowned by HEW in the letter of transmittal. In Mr. Carlucci's words, the plan does not take into consideration all our other research needs. And increasing the funding by the needed $46 million would deprive other projects of their funding.

Well, it is my hope that the Congress will provide the extra $46 million. We can get a 1,200,000 from the White House contingency fund. It is my understanding Congressman Steed feels the President has no need for this amount in a nonelection year. Not only should we provide this extra funding, but we should watch it closely and, if it is impounded, take the administration to court forthwith.

In reasserting our leadership in health, the Congress has enjoyed extraordinary success. But that is to be expected when we go to court—after all, we do not have the law on our side. A regular flow of court decisions has continually scored the administration for playing being a legislative body. In cases for housing, health, highways, education, pollution control, mental health centers, and neighborhood youth corps, funding has been mandated by the courts.

Mr. Chairman, let's keep a good thing going. The administration has thrown itself off kilter. I don't mean to suggest the Congress kick them while they are down, but the opportunity for Congress to reassert itself has arrived. Weinberger and company have demonstrated their bankruptcy of commitment to people and, particularly, people in need. I suggest we capitalize on their legal and ideological nakedness and proceed to legislate as we see fit.

We have been gentlemen; we have behaved in an absolutely impeccable manner; we have attempted every possible means of compromise and consensus. Well, we now know it won't work and if we don't get moving in this particular area of health, there won't be any-

thing much left to save, when this administration departs for their sunshine sanctuaries and leave us standing in the wreckage.

Mr. Chairman, I am appearing before your subcommittee to express not only my concern for these specific health care sabotage efforts of the administration. I also wish to acknowledge the proper jurisdiction and leadership of this committee in the health care field.

We need this committee's leadership in moving ahead on the research and treatment frontiers of medicine. We also need your leadership in this period of crisis—a crisis the administration has provoked and designed—a crisis that could leave us with nothing but quicksand as a structural basis for building a national health care and insurance system.

Right now we still have the bare bones of the structure we will need. But if we permit this administration to continue their depredations, we may very well be left with nothing, and arguments that a national health care system is too expensive may very well be perfectly true.

Mr. Chairman, I request inclusion of my printed statements and attachments in the record. And in closing, I should like to present the committee and the Congress with this advice from Macbeth, V. 7, "And be these juggling fiends no more believed, that palter with us in a double sense; that keep the word of promise to our ear, and break it to our hope."

Thank you, Mr. Chairman.

[Testimony resumes on p. 32.]

[Mr. Carey's prepared statement and attachments follow.]

STATEMENT OF HON. HUGH L. CAREY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. Chairman, I am very pleased to be here and take advantage of your kind offer to discuss with the Committee some of my concerns relative to the series of destructive "efficiency reorganizations proposed or initiated by the Department of Health, Education, and Welfare.

I also appreciate this opportunity to communicate the views over 35 Members of the House share with me concerning the specific ill-effects the reorganization at HEW will have on Maternal and Child Health Care programs throughout the Nation. These gentlemen joined me in writing the Secretary of HEW, requesting specific answers to very detailed and pointed questions about this proposed reorganization.

Mr. Chairman, before proceeding to the specifics of my testimony, I should like, as a member of the House Ways & Means Committee, to assure you of my wholehearted support of your efforts in designing national health care legislation. We at Ways & Means may be revenue experts, but we certainly look to you and the membership of your distinguished Subcommittee for guidance in both developing health care programs and in fighting off ill-advised attacks on those programs presently struggling to survive.

Mr. Chairman, the second leading cause of death in the United States is birth. Heart disease takes over 700,000 a year; cancer takes about 300,000; stroke—over 200,000; accidents—about 140,000. Infant mortality, however, takes 560,000 lives a year. And while it certainly is not the primary concern here, total lifetime earnings lost through infant mortality approach $90 billions. Mr. Chairman, that is approximately 10% of our GNP being lost, along with the priceless lives of Americans who will never know that name.

We are all aware of the U.S. international standing in infant mortality. It is a needless disgrace for this Nation and an even more needless time of agony for parents looking forward to the lives of healthy, happy children. I emphasize the word "needless", because that is exactly what the tragic infant mortality figures of the United States are.

The Congress has had testimony from the most distinguished medical scientists, practitioners, and pediatricians in the Nation. They all state unequivocally that

the U.S. does have the capability to substantially reduce these figures. We do have the know-how, the techniques, the health care teams, and potentially, the funds needed to see a national maternal and child health care system really work.

Mr. Chairman, dramatic proof of that can be seen in every health care area served by a Title V Maternal and Infant Care project. In my own 15th Congressional District in Brooklyn, the project area of Red Hook showed a reduction of infant mortality from 29.9 per one thousand live births in 1960, to 17.4 in 1971. And, Mr. Chairman, similarly remarkable figures are bing achieved all across the Nation. They are being achieved because the Congress has stuck to its guns and has continued to protect these life-giving and life-saving projects from both fiscal malnutrition and eventual starvation, "efficiency" shake-ups designed to deprive these projects and programs of support, morale, and leadership.

Mr. Chairman, in your own district in Florida, the West Palm Beach MIC project has reduced infant mortality from 29.2% in 1965 to 22.3% in 1969. MIC projects were initiated in Dade County in 1966 and I think the following figures need no elaboration. In 1967 the birth rate for all Dade County was 14.2; the infant mortality rate for the county was 24 and the mortality rate for the MIC areas was 13. In 1972 the birth rate for all Dade County was 13.3; the infant mortality rate for the County was 16.6 and the mortality rate for the MIC areas was 4, per 1,000 live births.

Figures such as these concerning our own people would seem to be reason enough for us to continue and redouble our efforts to safeguard the work now being done in this vital area and to see that these pockets of adequate health care become, in the next few years ahead, the national system of maternal and child health care we need—a system that will blend with and reinforce whatever administrative and operational structures the Congress establishes for comprehensive national health care.

Mr. Chairman, discussion of anything national in scope necessarily brings into play serious examination of and deliberation on the national philosophy underlying and supporting any national-impact proposal. We are discussing what you, I, and others in the Congress, know eventually will become a national, comprehensive, health care system. And we are discussing this in the context of the various medical research, education health-care, and delivery systems that Congress has designed, built, and funded over decades, in preparation for just such a comprehensive national system.

I should like, at this point, to quote from expressions by two Secretaries of Health, Education, and Welfare of what their personal philosophy is regarding a Federal commitment to health care.

First: "The main thing I would like as sincerely as I possibly can convey, is our absolute and total commitment to assure that health care is constantly improved . . . and that it will not be denied to anyone by the irrelevant factor or their not having sufficient income."

Second: "The great debate about Federal responsibility in health has to a considerable extent been resolved. Our health problems—whether they involve the menace of air and water pollution or the quality of care in hospitals and nursing homes—are now seen as national problems."

From listening to these two statements, one could very easily and justifiably state they both were uttered by the same man, or by men of very similar ideals and commitment to the improvement of health care in this Nation. Well the first assurance was delivered by the present Secretary of Health, Education, & Welfare, Mr. Weinberger. The second was uttered by Mr. Gardner, also Secretary of H.E.W., when he made that statement.

But, Mr. Chairman, deeds indicate far more clearly than words the measure of commitment to Federal leadership and Federal assistance to "constantly improved" health care.

The distinguished Chairman of the parent Interstate and Foreign Commerce Committee, Congressman Staggers, has just released figures and correspondence with Secretary Weinberger which display clearly the massive impoundments of appropriated health care funds during fiscal 1973. They, more than any other evidence are an overwhelming indictment of this Administration's lack of commitment to health improving care for all Americans.

A total of $1,095 billion in appropriated funds, released by the Office of Management and Budget, was impounded on authority of the Secretary. Usually OMB does the routine, every-day impounding in this Administration. However, it would seem the present Secretary's good judgment could be relied upon in the managing of these funds mandated by the Congress to make and keep America

healthy. It is also significant that while Chairman Staggers initiated his health impoundment inquiry with H.E.W. several months before the end of the fiscal year, the reply from H.E.W. was not sent to the Chairman until well into the first month of the new fiscal year. (Mr. Chairman, at this point in my statement, I ask that the correspondence between Chairman Staggers and Secretary Weinberger, plus the attached memoranda and tables be printed in the record.) [See attachment No. 1.]

Mr. Chairman, the necrology of health-care hopes and programs is practically endless and I find this continued impoundment, budget slashing, administrative legerdemain, and equivocation increasingly outrageous. I frankly take very personally this assault on American health care structures we in the Congress have labored to build over the past few decades.

I think in Washington you have to expect a certain amount of playing politics in various government cabinet departments. I can put up with dickering with military bases, or highway location gamesmanship, or government contract competition; but when you start playing politics with, or imposing personal ideologies on the health care of this Nation, I think it is about time to draw the line.

I know what access to outstanding medical care means to a family. I've been going out to N.I.H. on a family mission, week in and week out, for the last seven months. I have seen the expertise, dedication and humanity of that magnificent organization. And while they have not yet tried direct bureaucratic euthanasia on N.I.H., this Administration's track record on health care indicates that nothing is safe or sacred.

Time does not permit a discussion of all the failures, backing-and-filling, and misleading statements of this Administration on National health insurance, Health Maintenance Organizations; failures to spend highly publicized funds for cancer and heart and lung research.

However, I would like to outline briefly the recent scenario on securing an extension of project-funding for Maternal and Child Health Care projects funded under Title V of the Social Security Act.

This program comes under the jurisdiction of the Ways & Means Committee because its enabling legislation in 1965 was an amendment of the Social Security Act. Back in 1969, the Congress authorized a change in the method of funding. Health Care allocations were to be given directly to State government under a formula grant mechanism. The states were then to provide funding for health care programs, based on its own ordering of spending priorities.

While the States may well be given credit for good intentions concerning continued adequate funding for Maternal and Child Health Care projects, the liaison between H.E.W. and state health departments was practically non-existent on this funding change.

Secretary Weinberger, subsequent to the extension of project funding for F.Y. 1973, stated in a letter to Ways & Means Chairman Wilbur Mills, dated April 9, 1973, that, "Planning for the changeover is progressing well." (Mr. Chairman, at this point in my statement, I would like to insert in the record a copy of this letter.) [See attachment No. 2.]

Mr. Chairman, that statement can only be called misleading, at best. The staff of the Ways & Means Committee have right now in their possession statements from directors of projects all over the Country, stating unequivocally that if project funding is not extended for another year, that meant the end of their program. They stated further that no plans had been made on the state level to continue their programs and that their staffs were leaving, morale was low and they were preparing to close their doors. (Mr. Chairman, at this point I would like to insert in the record the letter I sent to the membership of the Ways & Means Committee concerning project fund extension for these projects.) [See attachment No. 3.]

The letter explains the vital necessity for this extension and outlines what would be lost by failure of the Congress to act before the end of the fiscal year. Where the letter indicates "Insert" a paragraph was inserted quoting the director of a project in the Members District or representative area as to the discussion effect of our failure to extend.

(Mr. Chairman, I would also like, at this point, to insert floor remarks of mine during debate on final passage of legislation containing the needed project-funding extension.) [See attachment No. 4.]

This speech includes a press report on the protest resignation of Dr. Arthur Lesser, veteran director of MCH programs in the Department of H.E.W.

Mr. Chairman, this story, plus information secured from highly respected health care professionals, both in and out of government, prompted my immediate

interest in the proposed reorganization at H.E.W. that is part of the direct focus of these hearings. These gentlemen confirmed what Dr. Lesser stated in his announcement of resignation: This reorganization was designed to strip various categorical programs, such as HMO's and MCH, of needed professional and support personnel. Leaving the up-graded Asst. Bureau directors in charge of these down-graded programs with only five or six apologists, would effectively kill the programs they were proposing to make more "efficient."

By submitting a budget request already containing 53 less positions, and then moving the remaining professional and support personnel to the office of the Bureau Director, the Department could claim to be streamlining the whole operation, while not actually cutting any personnel through reorganizaion itself. (Mr. Chairman, at this point in the record, I should like to insert an organizational chart that shows the proposed new disposition of programs and personnel.) [See attachment No. 5.]

This chart makes clear this reorganization effectively deprives these duly approved and funded programs of adequate support and leadership. Again, we see an example of this Administration's back-door method of getting rid of programs they don't like. "Just starve them of funds, and personnel, then go to the Congress and say they don't work, the experiment is a failure, and we should cease funding them altogether." Well, Mr. Chairman, I'm sure that if you and I have anything to do or say about it, this will most certainly not come about.

Mr. Chairman, as an expression of increasing Congressional concern over the obvious ill-effects on these six programs within the Bureau of Community Health, 34 of my House Colleagues joined with me in writing Secretary Weinberger. We stated that it is our belief that this reorganization is not aimed at increasing efficiency, but is, as Dr. Lesser stated, ". . . another disregard for the intent of Congress."

We asked if the Department plans to discuss this with the Congress, or, at least, ask informal approval of the plan. We requested clarification of how H.E.W. expects transferred program people to service programs to which they were attached by statute. We also asked how the Department planned to move in light of the recent project-funding extension of Title I Maternal and Child Health Care programs. (Mr. Chairman, at this point in the record, I should like to insert the dear colleague letter, the letter to Secretary Weinberger, and the press release containing the names of the Members who originally joined with me in this effort.) [See attachments No. 6, 7, and 8.]

Mr. Chairman, I hope I have been able to provide some information for the record and to assist you in your efforts to bring some humanity and common sense to the way the Department of Health, Education and Welfare is approaching their responsibility to look after the needs of all Americans in health and other vital areas of our national life.

I trust that we are now seeing in the Congress a determination to set this Administration right on who decides the national spending priorities of this Nation. If the Secretary of H.E.W. does not feel compelled by either human compassion or his oath of office to look after those least able to help themselves, we in the Congress must take a far closer look at the every administrative and organizational move of the Department.

Thinking back on men such as Fogarty, Laird, Hill, and others in the Congress, who devoted their lives to securing Americans this health-care beachhead, should inspire us to continue in this vital struggle. Americans, with the rest of humanity have faced up to and conquered war, death, pestilence, and famine. And, if necessary, we shall transcent whatever health-care horsemen of the apocalypse may appear.

ATTACHMENT NO. 1

U.S. House of Representatives,
Committee on Interstate and Foreign Commerce,
Washington, D.C., July 25, 1973.

Memorandum

Subject: Fiscal year 1973 budget.

The attached materials detail the $1.095 billion which the Department of Health, Education and Welfare had available for obligations in fiscal year 1973 and failed to obligate. Included with tables which break this money down by programs are relevant correspondence between Chairman Staggers and Secretary Weinberger, [exhibit No. 3] which are available for quotation.

The major amounts "impounded" are summarized in the first table with the items of particular interest underlined. [Exhibit No. 1.]

The tables provided by HEW [exhibit No. 2] show in their first column the authorized continuing resolution level. These amounts were determined by HEW and OMB by using the smallest of the following four figures for any given program: 1972 obligations, the original 1973 budget request submitted in January 1972, the amount appropriated in the second House Appropriations bill, or the amount appropriated in the second Senate Appropriations bill. These figures represent the amount available to HEW for obligation and expenditure in fiscal year 1973. The second column shows the operating level, or the amount actually anticipated for obligation. The third column shows the differences, and any positive difference represents "impounded" money. I believe that technically these moneys were not impounded since they were released by OMB to HEW who in turn failed to obligate them. This is legal quibble and certainly the ultimate affect is the same, a frustration of the Congressional intent.

It is worth noting that the fiscal year 1972 obligating level for HSMHA was $1.965 million and for NIH $2,217 million. These amounts in each case are less than the amounts available for obligation (the appropriations), and more than the amount which HEW actually spent.

As a final note, observe that the information was requested of HEW prior to the end of the fiscal year but not provided until immediately after its end.

Attachments:

EXHIBIT NO. 1

FY 1973 Health Money Not Spent in Summary

[Items of Special Interest are Italicized]

	In millions
Mental health programs	[1] $199. 2
(Apparently includes the $40 million for CMHC staffing released at the end of the year under court order.)	
Health Services R. & D	13. 0
CHP	6. 9
RMP	89. 9
Hill-Burton	195. 2
Comprehensive health services projects	6. 0
Maternal and child health projects	12. 8
Family planning	32. 4
Preventive and public health services	16. 0
HSMHA total	567. 6
National Cancer Institute	58. 9
National Heart and Lung Institute	44. 2
(All other research institutes were also subject to some withholding of funds.)	
NIH Research Total	226. 0
Support for MD's, DO's, DDS's	189. 0
Support for nurses	69. 7
Support for public health manpower	6. 6
Support for allied health manpower	10. 5
Health manpower total	[2] 297. 5
NIH total	527. 9

[1] Totals are not those of the figures shown since not every small failure to obligate money is shown.

[2] Probably includes podiatry and other VOPP's funds released at the end of the fiscal year under court order.

* * *

Exhibit No. 2

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE—COMPARISON OF FISCAL YEAR 1973 OPERATING LEVEL WITH THE 1973 CONTINUING RESOLUTION LEVEL FOR HEALTH PROGRAMS

Appropriation/activity	Authorized continuing resolution level (budget authority)	Fiscal year 1973 operating level (budget authority)	Difference
Food and Drug Administration	$9,528,000	$9,528,000	
Health Services and Mental Health Administration	2,227,887,000	1,660,301,000	$567,586,000
National Institutes of Health	2,530,812,000	2,002,967,000	527,845,000
Total, health	4,768,227,000	3,672,796,000	1,095,431,000
FOOD AND DRUG ADMINISTRATION			
Food, drug, and product safety:			
1. Foods			
2. Drugs and devices	9,528,000	9,528,000	
3. Product safety			
4. Program management			
Total			
Buildings and facilities			
Revolving fund for certification			
Total, Food and Drug Administration	9,528,000	9,528,000	
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION			
Mental Health:			
1. Research:			
(a) Grants	104,400,000	80,253,000	24,147,000
(b) Direct operations	44,133,000	44,473,000	−340,000
Subtotal	148,533,000	124,726,000	23,807,000
2. Manpower development:			
(a) Training grants and fellowships	120,050,000	86,274,000	33,776,000
(b) Direct operations	7,921,000	7,998,000	−77,000
Subtotal	127,971,000	94,272,000	33,699,000
3. State and community assistance:			
(a) Community mental health centers:			
(1) Construction	20,000,000		20,000,000
(2) Staffing	165,000,000	125,100,000	39,900,000
Subtotal	185,000,000	125,100,000	59,900,000
(b) Narcotic addiction	91,298,000	93,755,000	−2,457,000
(c) Alcoholism:			
(1) Grants to States	60,000,000	30,000,000	30,000,000
(2) Project grants	70,193,000	30,884,000	39,309,000
Subtotal	130,193,000	60,884,000	69,309,000
(d) Mental health of children	20,000,000	8,600,000	11,400,000
(e) Direct operations	7,354,000	7,518,000	−164,000
Subtotal	433,845,000	295,857,000	137,988,000

EXHIBIT NO. 2—Continued

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE—COMPARISON OF FISCAL YEAR 1973 OPERATING LEVEL WITH THE 1973 CONTINUING RESOLUTION LEVEL FOR HEALTH PROGRAMS—Continued

Appropriation/activity	Authorized continuing resolution level (budget authority)	Fiscal year 1973 operating level (budget authority)	Difference
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION—Continued			
Mental Health—Continued			
4. Rehabilitation of drug abusers	$14,022,000	$11,565,000	$2,457,000
5. Program support	19,352,000	18,094,000	1,258,000
Total	743,723,000	544,514,000	199,209,000
St. Elizabeths Hospital	30,664,000	[1] 36,941,000	—6,277,000
Health services planning and development:			
1. Health services research and development	64,501,000	51,500,000	13,001,000
2. Comprehensive health planning	41,686,000	34,800,000	6,886,000
3. Regional medical programs	150,000,000	60,100,000	89,900,000
4. Health maintenence organizations			
5. Medical facilities construction:			
(a) Construction grants	197,200,000	2,000,000	195,200,000
(b) Interest subsidies	2,500,000	2,500,000	
(c) District of Columbia medical facilities			
(d) Direct operations	3,369,000	3,315,000	54,000
Subtotal	203,069,000	7,815,000	195,254,000
6. Program direction	2,817,000	2,901,000	—84,000
Total	462,073,000	157,116,000	304,957,000
Health servicas delivery:			
1. Comprehensive health services:			
(a) Grants to States	90,000,000	90,000,000	
(b) Project grants	116,200,000	110,200,000	6,000,000
(c) Migrant health grants	23,750,000	23,750,000	
(d) Direct operations	19,259,000	19,976,000	—717,000
Subtotal	249,209,000	243,926,000	5,283,000
2. Maternal and child health:			
(a) Grants to States	125,678,000	125,678,000	
(b) Project grants	101,330,000	88,549,000	12,781,000
(c) Research and training	21,392,000	21,392,000	
(d) Direct operations	4,276,000	4,360,000	—84,000
Subtotal	252,676,000	239,979,000	12,697,000
3. Family planning services:			
(a) Grants and contracts	137,024,000	104,615,000	32,409,000
(b) Direct operetions	2,065,000	2,032,000	33,000
Subtotal	139,089,000	106,647,000	32,442,000
4. National Health Service Corps	8,998,000	11,000,000	—2,002,000
5. National Health Service Scholarships			
6. Patient care and special health services	93,952,000	95,915,000	—1,963,000
7. Regional office, central staff	5,522,000	5,630,000	—108,000
8. Program direction	6,568,000	6,310,000	258,000
Less trust fund transfer	—4,719,000	—5,202,000	483,000
Total	751,295,000	704,205,000	47,090,000
Prevantive health servicas:			
1. Disease control:			
(e) Infectious diseases:			
(1) Research grants	2,215,000	2,215,000	
(2) Project grants	39,300,000	34,850,000	4,450,000
(3) Direct operations	37,893,000	38,954,000	—1,061,000
Subtotal	79,408,000	76,019,000	3,389,000
(b) Nutritional and chronic diseases	5,761,000	4,251,000	1,510,000
(c) Laboratory improvement	10,168,000	7,892,000	2,276,000
Subtotal	95,337,000	88,162,000	7,175,000
2. Community environmental manegament:			
(a) Grants	25,900,000	21,500,000	4,400,000
(b) Direct operations	5,175,000	5,229,000	—54,000
Subtotal	31,075,000	26,729,000	4,346,000

EXHIBIT NO. 2—Continued

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE—COMPARISON OF FISCAL YEAR 1973 OPERATING LEVEL WITH THE 1973 CONTINUING RESOLUTION LEVEL FOR HEALTH PROGRAMS—Continued

Appropriation/activity	Authorized continuing resolution level (budget authority)	Fiscal year 1973 operating level (budget authority)	Difference
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION—Continued			
Preventive health services—Continued			
3. Occupational health:			
(a) Grants	$4,414,000	$2,852,000	$1,562,000
(b) Direct operations	24,428,000	21,847,000	2,581,000
Subtotal	28,842,000	24,699,000	4,143,000
4. Program direction	4,618,000	4,300,000	318,000
Total	159,872,000	143,890,000	15,982,000
National health statistics	18,514,000	18,514,000	
Retirement pay and medical benefits for commissioned officers	29,163,000	29,163,000	
Buildings and facilities	19,457,000	12,550,000	6,907,000
Office of the Administrator	13,126,000	13,408,000	−282,000
Total, Health Services and Mental Health Administration	2,227,887,000	1,660,301,000	567,586,000
NATIONAL INSTITUTES OF HEALTH			
National Cancer Institute	429,205,000	433,346,000	58,859,000
National Heart and Lung Institute	300,000,000	255,783,000	44,217,000
National Institute of Dental Research	46,991,000	40,879,000	6,112,000
National Institute of Arthritis, Metabolism, and Digestive Diseases	167,316,000	143,273,000	24,043,000
National Institute of Neurological Diseases and Stroke	130,672,000	107,931,000	22,741,000
National Institute of Allergy and Infectious Diseases	113,414,000	103,022,000	10,392,000
National Institute of General Medical Sciences	183,171,000	154,205,000	28,966,000
National Institute of Child Health and Human Development	130,429,000	111,396,000	19,033,000
National Eye Institute	38,562,000	34,442,000	4,120,000
National Institute of Environmental Health Sciences	30,956,000	26,220,000	4,736,000
Research Resources	75,073,000	72,918,000	2,155,000
John E. Fogarty International Center	4,666,000	3,957,000	709,000
Subtotal	1,713,455,000	1,487,732,000	226,083,000
Health manpower:			
1. Health professions:			
(a) Institutional assistance:			
(1) Capitation grants	165,900,000	152,200,000	13,700,000
(2) Startup and conversion assistance (3) Financial distress grants (4) Special projects	131,700,000	67,400,000	64,300,000
Subtotal	297,600,000	219,600,000	78,000,000
(b) Student assistance:			
(1) Direct loans	36,000,000	36,000,000	
(2) Scholarships	15,500,000	15,500,000	
(3) Loan forgiveness	17,000,000	6,000,000	11,000,000
Subtotal	68,500,000	57,500,000	11,000,000
(c) Construction assistance:			
(1) Grants	100,000,000		100,000,000
(2) Interest subsidies	1,000,000	1,000,000	
Subtotal	101,000,000	1,000,000	100,000,000
(d) Dental health activities	(1)	(1)	(1)
(e) Educational assistance	(1)	(1)	(1)
(f) Direct operations	(1)	(1)	(1)
Subtotal	467,100,000	278,100,000	189,000,000
2. Nursing:			
(a) Institutional assistance:			
(1) Capitation grants			
(2) Startup assistance			
(3) Financial distress grants			
(4) Special projects			
Subtotal	75,500,000	28,400,000	47,100,000
(b) Student assistance:			
(1) Direct loans	24,000,000	21,000,000	3,000,000
(2) Scholarships	21,500,000	19,500,000	2,000,000
(3) Traineeships	12,500,000	15,900,000	−3,400,000
Subtotal	58,000,000	56,400,000	1,600,000

EXHIBIT NO. 2—Continued

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE—COMPARISON OF FISCAL YEAR 1973 OPERATING LEVEL WITH THE 1973 CONTINUING RESOLUTION LEVEL FOR HEALTH PROGRAMS—Continued

Appropriation/activity	Authorized continuing resolution level (budget authority)	Fiscal year 1973 operating level (budget authority)	Difference
NATIONAL INSTITUTES OF HEALTH—Continued			
Health manpower—Continued			
Nursing—Continued			
(c) Construction assistance:			
(1) Grants	$20,000,000	----------	$20,000,000
(2) Interest subsidies	1,000,000	(2)	1,000,000
Subtotal	21,000,000	----------	21,000,000
(d) Educational assistance	(1)	(1)	(1)
(e) Direct operations	(1)	(1)	(1)
Subtotal	154,500,000	$84,800,000	69,700,000
(1) Grants	20,000,000	----------	20,000,000
(2) Interest subsidies	1,000,000	(2)	1,000,000
Subtotal	21,000,000	----------	21,000,000
(d) Educational assistance	(1)	(1)	(1)
(e) Direct operations	(1)	(1)	(1)
Subtotal	154,500,000	84,800,000	69,700,000
3. Public health:			
(a) Institutional assistance	12,000,000	5,940,000	6,060,000
(b) Student assistance	9,600,000	9,000,000	600,000
(c) Direct operations	(1)	(1)	(1)
Subtotal	21,600,000	14,940,000	6,660,000
4. Allied health:			
(a) Institutional assistance	16,000,000	5,500,000	10,500,000
(b) Student assistance	3,750,000	3,750,000	----------
(c) Educational assistance	(1)	(1)	(1)
(d) Direct operations	(1)	(1)	(1)
Subtotal	19,750,000	9,250,000	10,500,000
5. Special educational programs:			
(a) Educational initiative awards	(1)	(1)	(1)
(b) Computer technology and educational assistance	(1)	(1)	(1)
(c) Direct operations	(1)	(1)	(1)
Subtotal			
6. Program direction and manpower analysis	75,678,000	53,976,000	21,702,000
Total	738,628,000	441,066,000	297,562,000
National Library of Medicine	28,568,000	25,230,000	3,338,000
Buildings and facilities	8,500,000	8,000,000	500,000
Office of the Director	12,042,000	11,680,000	362,000
Scientific activities overseas	25,619,000	25,619,000	----------
Health education loans: Payment of sales insufficiencies and interest loans	4,000,000	4,000,000	----------
Intragovernmental funds			
Total, National Institutes of Health	2,530,812,000	2,002,967,000	527,845,000

[1] Included in final line entry—program direction and manpower analysis.
[2] Fiscal year 1973 interest subsidy funds ($1,000,000) will be carried over to fiscal year 1974.

EXHIBIT NO. 3

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C., May 29, 1973.

Hon. CASPAR WEINBERGER,
Secretary, Department of Health, Education, and Welfare,
Washington, D.C.

DEAR MR. SECRETARY: We recently discussed funding of the Hill-Burton program during fiscal year 1973, and I would appreciate receiving further information on this subject.

Specifically, I would like to know the amounts of money which have been and will be released to the states for purposes of making grants under the Hill-Burton

program this fiscal year. How much money does HEW feel has been appropriated for expenditure during this fiscal year under the various parts of the Hill-Burton legislation? How does the Section 601 provision of the Medical Facilities Construction and Modernization Amendments of 1970 apply to expenditures in this area? What general counsel opinions have you obtained relevant to these issues?

Thank you for your assistance.

Sincerely yours,

HARLEY O. STAGGERS, *Member of Congress,*
Chairman.

* * *

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C., June 8, 1973.

Hon. CASPAR WEINBERGER,
Secretary, Department of Health, Education, and Welfare,
Washington, D.C.

DEAR MR. SECRETARY: In reviewing the FY 1973 appropriations and proposed obligations for the Health Services and Mental Health Administration and the National Institutes of Health, it appears that the Congress has appropriated approximately $1.1 billion which the Department of HEW is not planning to obligate. These amounts include the following:

	In millions
CMHC staffing	$40
Alcoholism programs	82
Hill-Burton	195
Family planning	33
National Cancer Institute	60
National Heart and Lung Institute	42
Medical research in total	230
Health manpower	300

Since the FY '73 Labor-HEW continuing resolution has the full force of law, these amounts are apparently health monies which HEW is proposing to impound. While most legal scholars feel that impoundment is illegal, I do understand that there is some controversy on this point. However, with regard to health monies, there is additional legal authority designed to assure that such monies are expended (section 601 of the Medical Facilities Construction and Modernization Amendments of 1970).

Would you provide me with a detailed breakdown of all anticipated differences in health between the FY '73 appropriations and obligations. In addition, I would like to see legal justification for the failure to expend appropriated funds; specifically any opinions from the General Counsel of HEW on this subject including the applicability of section 601.

Sincerely yours,

HARLEY O. STAGGERS, *Member of Congress,*
Chairman.

* * *

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF THE SECRETARY,
Washington, D.C., July 3, 1973.

Hon. HARLEY O. STAGGERS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives,
Washington, D.C.

DEAR MR. CHAIRMAN: Thank you for your letters of May 29 and June 8 concerning appropriations for Hill-Burton and other health programs. Since your letters cover similar issues, I am responding to both by this one letter. I have also received your letter of June 13.

Enclosed are two tables. The first (enclosure 1) describes the Department's spending for the Hill-Burton program, title VI of the Public Health Service Act. It shows new budget authority available under the Continuing Resolution, the amount of funds carried over from prior years' appropriations, and the Department's FY 1973 operating level. The second table (enclosure 2) [printed as exhibit No. 2, p. 17] provides the data requested in your June 8 letter for all health programs covered by the FY 1973 Continuing Resolution.

The meaning of Section 601, about which you enquire, remains unclear and most debatable. To my knowledge, no court has yet attempted to construe section 601 or the companion provision in the education area, section 415 of the General Education Provisions Act. It seems appropriate for the Department of Justice to decide whether to release letters they sent to me some time ago when I occupied a different governmental position.

As to the legal justification for impounding funds, I refer you to the February 6, 1973, Senate testimony of Deputy Attorney General Sneed on this subject. His written statement, a copy of which is enclosed for your convenience [not printed], is printed in Joint Hearings before the Ad Hoc Subcommittee on Impoundment of Funds of the Committee on Government Operations and the Subcommittee on Separation of Powers of the Committee on the Judiciary, United States Senate, on S. 373, 93d Congress, 1st Session, beginning at page 364.

Sincerely,

CASPAR W. WEINBERGER,
Secretary.

Enclosures.

ENCLOSURE NO. 1

MEDICAL FACILITIES CONSTRUCTION (HILL-BURTON)

Sec. 601	New budget authority authorized under the 1973 continuing resolution	Carry-over July 1, 1972	Fiscal year 1973 operating level [1]
Subsec. (a)(1). Long-term care facilities	$20,800,000	$30,012,000	$17,003,000
Subsec. (a)(2). Outpatient facilities	70,000,000	99,883,000	30,215,000
Subsec. (a)(3). Rehabilitation facilities	15,000,000	20,536,000	11,598,000
Subsec. (b). Hospitals and public health centers	41,400,000	54,139,000	26,426,000
Subsec. (c). Modernization of facilities	50,000,000	91,994,000	77,864,000
Total	197,200,000	296,564,000	[2] 163,106,000

[1] Includes $2,000,000 allocated for State administration expenses.
[2] Includes actual obligations through May 31, 1973, plus an estimate of how June obligations will be distributed among subsections of the law. Determination of need is made in the field and the actual distribution may vary from the estimate.

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON INTERESTATE AND FOREIGN COMMERCE,
Washington, D.C., July 12, 1973.

Hon. CASPAR W. WEINBERGER,
Secretary, Department of Health, Education, and Welfare,
Washington, D.C.

DEAR MR. SECRETARY: Thank you for your letter of July 3 concerning health funds which you have impounded.

I am dismayed that you have felt it appropriate to impound the billion dollars your letter describes. I am not convinced that this is legal, necessary, or in the best interests of the people of our nation. I would be interested in a detailed, program-by-program, description of why you feel that these programs are inadequate, inappropriate, or unnecessary. They were created to meet specific needs of our population: the need for protection from disease be it infectious, nutritional, or chronic, the need for adequate supplies of health manpower, the need for health services and biomedical research, and the need for improved, or even adequate, health services of many kinds. Unless these needs in fact do not exist, or have been met, or are being met by alternative superior programs, than these impoundments must be considered a sad failure of our government's commitment to serve its people.

Yours,

HARLEY O. STAGGERS, *Member of Congress,*
Chairman.

ATTACHMENT NO. 2

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF THE SECRETARY,
Washington, D.C., April 9, 1973.

Hon. WILBUR D. MILLS,
Chairman, Committee on Ways and Means, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This is in further response to your letter of February 2 requesting detailed information about the findings set forth in the General Accounting Office report on the program under Title V of the Social Security Act. I appreciate the opportunity to advise you of the steps taken by the Department to assure an orderly transition to the States of the project grant authority in Title V. A detailed response to your questions is provided in the enclosed statement.

Planning for the changeover is progressing well. Draft proposed regulations relating to the programs of projects required for State plan approval by sections 505(a) (8), (9), and (10) of the Act have been developed and sent to the State health agencies for comment. Thoughtful responses have been received from 33 States to date. The draft is being revised to take these into account. Guidelines interpreting program concepts are being developed to help States meet the statutory and regulatory requirements.

The reporting systems have been simplified to adapt them to State usage. Proposed procedures for completing the transition from direct Federal financing to State financing have been developed and will be issued to State health agencies and other project grantees shortly.

Maternal and Child Health Service staff of the Health Services and Mental Health Administration have been working with States and project grantees on problems relating to the changeover since early December, 1972.

We will do our best to make the changeover from direct Federal project grants to provision of services by State health agencies with formula and matching funds as smooth as possible. As indicated in the enclosure, reductions in services may occur in some of the States with large urban areas but services not now available will be provided in other States. We think that these programs have carried out their objectives and demonstrated their value and that States will want to continue and expand effective projects.

Sincerely,

CASPAR W. WEINBERGER,
Secretary.

[Enclosures not printed.]

ATTACHMENT NO. 3

U.S. HOUSE OF REPRESENTATIVES,
Washington, D.C., June 15, 1973.

DEAR ———: During the executive session of the Ways & Means Committee held on Tuesday, June 5th, the Committee passed over legislation, (H.R. 7114), to extend project-grant funding, under Title V of the Social Security Act, for Maternal and Child Health Care.

Failure to extend project-funding for these programs will result in either their acute curtailment or effective demise. There are 139 projects in 38 states and two territories. They provide a complete range of medical services for over 800,000 maternity patients and children. These programs have resulted in dramatic drops in infant mortality rates in areas they cover. Preventive medical and dental care programs have also been extremely effective in raising the percentage of those youngsters and infants declared "healthy on examination". The nation-wide value of these programs is beyond dispute.

Should the Committee not provide an extension, total of $28,354,200 will be lost outright to 15 jurisdictions. While it may appear that some states are slated to gain a million or two dollars in overall formula grants, projects, even in those states, will likewise be very seriously affected—some to the point of shutting down all operations.

The Secretary of H.E.W. has assured the Chairman and Committee that a smooth transition can be accomplished in terminating project funding. He notes in his letter of April 9, 1973, that only those States most seriously affected by project funding termination may have some difficulty in adjusting.

However, it is my understanding, based on direct communications received from the directors of many projects, that an extension of at least another year is urgently needed to secure some alternate funding sources for their programs.

While it is hoped that ongoing projects would receive some funding channeled by the States from the new formula grants under Title V, there is no assurance that this will be the case. The Comptroller General has stated there is no way to trace funds to insure they are being used to continue the vital health care being delivered by these projects.

As I mentioned above, project directors, even in those states slated to receive slightly more funding under formula grants, have been able to neither secure alternate funding nor receive assurances from their state governments that funds approaching those needed for project continuation will be forthcoming.

Such statements have been received from the representative region of every Member of the Ways & Means Committee and from the states of all but two Members whose States either do not have projects, or whose participation is slight.

Based on direct statements of project directors and correspondence from the National Association of Maternity and Infant Care Projects, the American Medical Association, and the American Academy of Pediatrics, failure to extend Title V project funding will be a four-fold disaster:

First, the extremely important beginning we have made in both perinatal care and parent education will be lost;

Second, there is no way for the Congress to assure that the States will provide funds to make up for the 85–90% of project budgets now received under project funding;

Third, even if state funding is made available, processing of state assistance applications will cause an hiatus in care;

Fourth, the professional and para-medical staffs serving these projects will be dispersed and all voluntary work and assistance to these teams will cease.

This matter is clearly of vital and immediate concern to every member of the Committee and of the Congress. It is my hope that the Committee will be given the opportunity to reconsider this legislation, thus providing the time necessary to secure alternate methods of funding; restructure the formula of distribution; seek additional Federal appropriations, so that no state or project is even apparently short-changed in their access to funds; or all three.

I have attached a letter from the American Academy of Pediatrics addressed to each member of the Committee, stating the professional judgment of the men most closely associated with these projects and the care being provided over 800,000 mothers or mothers-to-be, and their children.

I urge your favorable consideration of both these letters, and concurrence with reconsidering and reporting this urgently needed legislation.

Sincerely,

HUGH L. CAREY, M.C.

ATTACHMENT NO. 4

[Excerpt From the Congressional Record—June 30, 1973]

Mr. CAREY of New York. One point, Mr. Chairman: With regard to the State of New York and unemployment compensation insurance benefits and the eligibility factor with regard to our committee's research on this point, again and again I have run into the problem that the geographical area of reporting that covers the statistics is regional, and until we cure that difficulty of the regional reporting, it is very hard to bring New York in under the 4½ percent without heavily increasing the burden across the country in other States that have a level above that level.

Mr. MILLS of Arkansas. I agree with the gentleman from New York.

Mr. CAREY of New York. I think it is something that is beyond the reach of the conferees. One more thing: I want to commend the chairman for his stamina and steadfastness in bringing into the conference, I believe, the provisions regarding maternal and child health care. Many States would have lost on these

and few States would have gained if the conference report had not gone into this. It is very important to keep these programs for parental and perinatal care ongoing.

Mr. Speaker, I should like to address some brief remarks to a specific amendment House conferees have brought back in disagreement. I refer to the extension, for one fiscal year, of project funding for Maternal and Child Health Care Centers, contained in the Senate version of the Debt Limit Extension.

I am very gratified that the conferees will permit the House to work its will on this and other vital amendments aimed at helping, in a most direct way, those least able to help themselves.

Extension of project funding for these centers will permit the continuation of these essential health care programs in 139 locations, in 38 States and two territories. Service is provided, just under the Maternal and Infant Care programs to, 800,000 expectant mothers, infants and youngsters.

Failure to provide this extension of project funding, under title V of the Social Security Act, would result in the eventual severe curtailment or effective demise of virtually all the centers across the Nation and cost New York City approximately $8 million in the coming fiscal year.

Mr. Speaker, the success of these programs is clearly and magnificently obvious. Infant mortallty has decreased substantially in those areas in which a project is operating. In my own district, for instance, the project area of Red Hook showed a reduction of infant mortality from 29.9 percent per one thousand births in 1960 to 17.4 percent in 1971.

Similar results have been achieved in the many projects, 11 in the Metropolitan New York area, throughout the Nation. Intensive care for premature infants has resulted in reductions of up to 25 percent in mortality rates.

Quite frankly, Mr. Speaker, unless the House permits this project-funding extension, funding is just not likely to be forthcoming from the States, and little has been done, to date, to provide for a smooth transition to full formula funding and assurance of adequate state funding for these centers. With no extension, most of these projects will just die, rendering useless over 5 years of progress in a team approach to maternal and child health care. We will also lose what has been gained in parental education in nutrition and hygiene and general perinatal care. These mothers and their children will be thrown back on the medical care junkheap, if we do not instruct our conferees to recede from disagreement to this vital amendment.

Mr. Speaker, the nationwide value of these programs is beyond dispute. Continuation of project funding is clearly of vital and immediate concern to every Member of Congress. I urge overwhelming approval of any motion to instruct the conferees to recede from disagreement to Senate amendment providing for a 1 year extension of project funding for Maternal and Child Health Care programs.

Mr. Speaker, the distinguished chairman of the House Ways and Means Committee, the gentleman from Arkansas (Mr. MILLS), Congressman BURKE, Congressman ROSTENKOWSKI, myself, and other members of the committee and the House, have worked very hard to secure this continuation of project funding. The distinguished senior Senator from Minnesota (Mr. MONDALE) and the chairman and members of the Senate Finance Committee are certainly to be commended for the yeoman duty they performed in behalf of this most important amendment.

My only concern, other than House approval of this amendment, is that the Department of Health, Education and Welfare, that bastion of defense for the rights, needs and equal opportunities of those unable to defend themselves, has begun to dismantle the present administrative structure that has been caring for these and other programs designed to safeguard the health of the American child.

This morning's Washington Post carries a story on page A2, explaining the reasons for the resignation of Dr. Arthur J. Lesser, veteran head of Federal programs for crippled children, infants, children and expectant mothers, Dr. Lesser states, in reply to Mr. Weinberger's assurances that this is merely an efficiency reorganization:

"This is the first step in the elimination of categorical programs. It is another disregard for the intent of Congress."

Mr. Speaker, it with continued shock and outrage that I have witnessed and continued to witness the arrogant destruction of programs the Congress and the American people have labored for decades to build and improve.

What form of callousness inhabits this administration? Is it that they realize they will not be running things come a few years hence and that they must

accomplish this seamy and illegal wasting of our health programs quickly and in such a way that their reconstruction will be a long and difficult work for the Congress and any succeeding administration? That would be the only explanation possible for this rampant disregard for the will of the Congress—a Congress, however, that has begun to fight strongly against this form of constitutional subversion.

Mr. Speaker, we have reached the point where the Congress is forced to seek relief in the courts via injunctions and suits to compel the executive to carry out the directives of the elected representatives of the people. I can assure my colleagues that this confrontation is just beginning. But I am sure we will carry it to a successful conclusion—a conclusion that will be effected legally and constitutionally and a conclusion that will restore fully the power of the Congress to legislate for the general welfare of the American people, without the hindrance of an administration supposedly in office to carry out the will of the Congress.

Mr. Speaker, it is my wish to insert at the conclusion of my remarks the Post story concerning the resignation of Dr. Lesser:

HEW Aide Quits Over Nixon Plan

Dr. Arthur J. Lesser, veteran head of federal health services for crippled children and low-income pregnant mothers said yesterday he is quitting to protest Nixon administration plans to break up his agency and make the director a "figurehead."

"This is the first step in the elimination of categorical programs," Lesser said. "It is another disregard for the intent of Congress."

Congress provides funds for some health services by specific category, such as maternal and child health care. The Nixon administration's revenue sharing concept, which does not apply to these programs, lumps the funds together and lets the states decide what the spending categories should be.

Lesser charged that under a reorganization of the Health Services and Mental Health Administration—a unit of the Department of Health, Education, and Welfare (HEW) the child and maternal health programs staff would be reduced from about 160 to six or seven and the other personnel would be given additional duties with other programs.

"There is no place for me in that kind of business," Lesser told UPI. He has been head of federal health services for children and mothers since 1952 and associated with the programs since 1941, but Friday will be his last day on the job.

At age 63, Lesser said he is not ready to retire. "But I certainly wouldn't continue as a figurehead or exhibit a in support of a reorganization of which I thoroughly disapprove," he said.

The General Accounting Office is investigating the reorganization to determine if any Congressional authority has been violated.

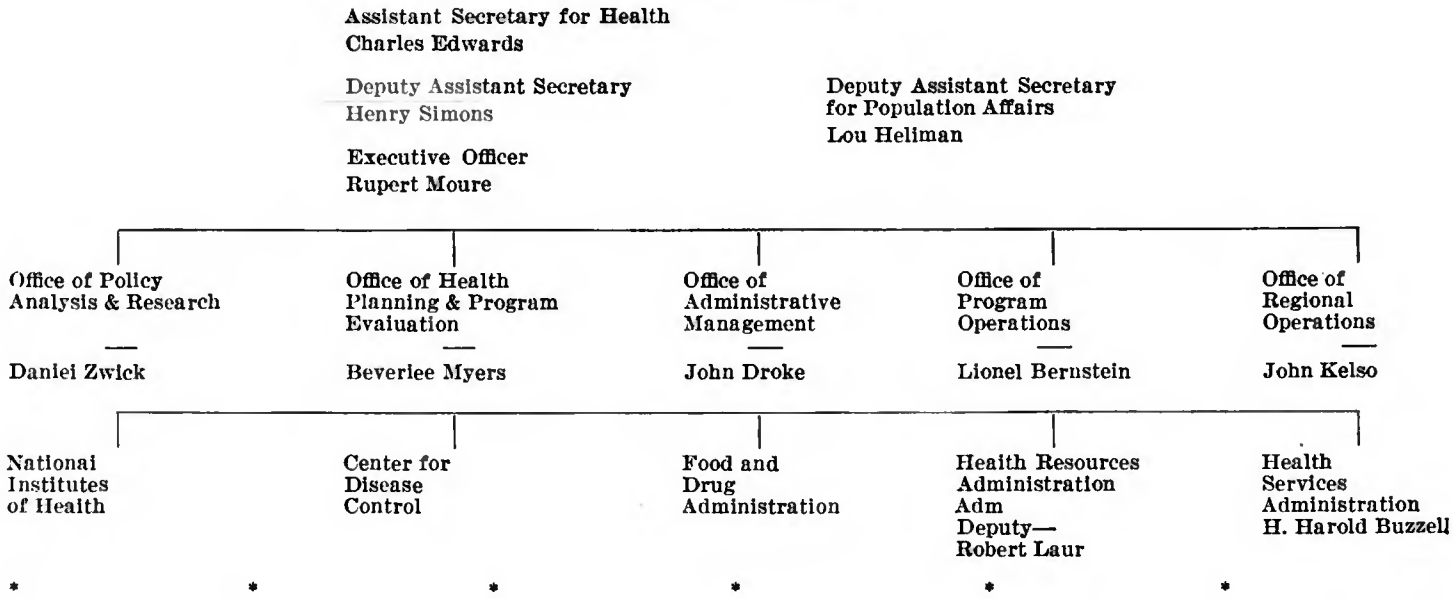
Under the plan to take effect next month, HEW Secretary Casper W. Weinberger said health services will be split into three major units to "increase the efficiency and effectiveness of the department's health programs."

Under the $244 million maternal and child health services program, some 500,000 crippled children, primarily in rural areas, receive medical care each year; 650,000 infants get well-baby care; 2 million to 3 million children receive school health examinations and immunizations, and needy pregnant mothers and children, mostly in big cities, get health examinations, dental care and other services to reduce high rates of infant mortality and promote good health.

Dr. Paul B. Batalden, chief of the bureau in which these services will be located, said there is no intent to phase them out.

"I would not have accepted that job if that had been the case," he said.

ATTACHMENT NO. 5



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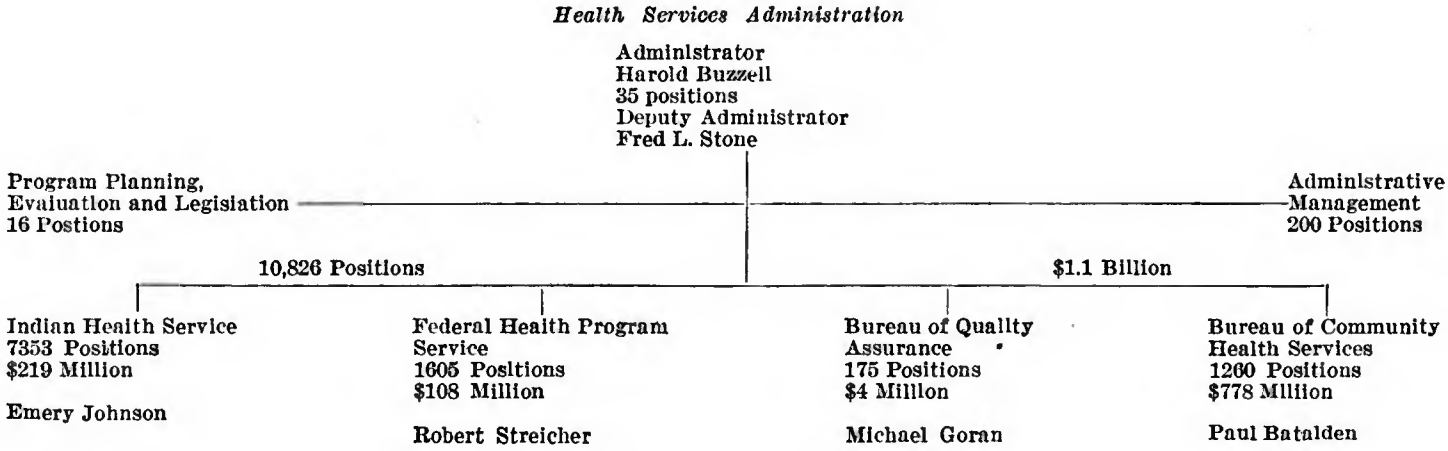

Health Services Administration
Administrator
Harold Buzzell
35 positions
Deputy Administrator
Fred L. Stone
Program Planning,
Evaluation and Legislation
16 Postions
Administrative
Management
200 Positions
10,826 Positions
$1.1 Billion
Indian Health Service
7353 Positions
$219 Million
Emery Johnson
Federal Health Program
Service
1605 Positions
$108 Million
Robert Streicher
Bureau of Quality
Assurance
175 Positions
$4 Million
Michael Goran
Bureau of Community
Health Services
1260 Positions
$778 Million
Paul Batalden

25-723 O - 74 -- 3

Bureau of Community Health Service

Director—Paul Batalden

Deputy Director—

Assistant Bureau Director (and Small Staff of 5–6) for Each Program Authorized by Legislation

Neighborhood Health Centers	Migrant Health	Family Planning Schultz—	Health Maintenance Organization MeLeod—out	National Health Service Corps Rimple	Maternal and Child Health Lesser—out Ehling

Executive Director—Ed Kelly

Policy Development Office	Clinical Services Office	Health Service Finance Office	Organization Development Office	Monitoring and Analysis Office
Translate Laws to Policy—Regulations	Professional Services, Staff Development, Professional, Coordination, Research	Third Party Financing Initiatives, Liaison with Titles 18 & 19	Provide Guidance on Systems Approach to Starting Activity, Convert Programs to More Efficient Type Operations, Move to Prepaid Programs	Reporting Requirements, Data Analysis, Use and Cost of Services

ATTACHMENT NO. 6

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., July 17, 1973.

DEAR COLLEAGUE: It is the intention of the Department of Health, Education, and Welfare to administratively reorganize the Health Services and Mental Health Administration into the Health Resources Administration and the Health Services Administration.

These proposed administrative changes, as outlined very broadly on page 18260 of the Federal Register of July 9, 1973, would seem to set the stage for what Dr. Arthur Lesser, in his statement of resignation as program director for Maternal and Child Health Care, protested would amount to, ". . . the first step in the elimination of categorical programs. It is another disregard for the intent of Congress." Please see my remarks on Page H. 5773 of the June 30, 1973 Record (2d column, last paragraph, et seq.), for further particulars on this issue and the protest resignation of this highly respected, veteran health professional.

As the attached letter to Secretary Weinberger spells out, this "reorganization" would effectively deprive six categorical programs of their immediate support, program and administrative personnel. It would further seem to be in conflict not only with funding and personnel accountability contained in present law, but with the very recent intent of the Congress in providing an extension of specific program funding for Title V Maternal and Child Health Care programs—extension of a *categorical, not formula* method of fund distribution.

It is my hope that you will be able to join with me in this letter to Secretary Weinberger, asking for clarification of the Department's specific intentions with regard to Maternal and Child Health Care, and other categorical programs being lumped together for purposes that may be "efficient" but which have been condemned by deeply worried health care professionals as destructive of the health care goals the Congress intended in creating them.

The specifics of this letter and the attached have the strong endorsement of the American Academy of Pediatrics. Should you wish to join in this letter please call Miss Golden on ext. 54105 by noon Friday, July 20, 1973.

Sincerely,

HUGH L. CAREY, M.C.

ATTACHMENT NO. 7

Hon. CASPAR WEINBERGER,
Secretary, Department of Health, Education, and Welfare,
Washington, D.C.

DEAR MR. SECRETARY: The lack of current information regarding the proposed reorganization of Health Services and Mental Health Administration into the Health Resources Administration and the Health Services Administration is causing anxiety, and it is hoped that your response to this inquiry might convey Administration proposals as they might affect the effective achievement of program goals directed by the Congress. Specifically, concern is mounting that the new organizational structure will be incapable of fulfilling the purpose for which each individual program had been initially established.

The organization proposed reflects a new Bureau of Community Health Services comprised of Maternal and Child Health, Family Planning, Migrant Health, Neighborhood Health Centers, National Health Service Corps and Health Maintenance Organization. The director of each of these programs will become an Assistant Bureau Director. It appears that each program will be treated similarly regardless of whether they are equal in scope, history, funding, accomplishments, expectations or mandate. In addition, while the Director of Maternal and Child Health Service for example, maintains apparent responsibility for the program, he has no line authority over employees justifiably employed with Title V funds, since the personnel are redistributed among the various offices, save five or six employees who will work on the Assistant Bureau Director's immediate staff, primarily as apologists.

This reorganization plan, unlike previous plans, appears to dismantle the maternal and child health program components rather than merely give them new administrative superiors. This appears as not only unsound health policy and unwise administrative practice, but a disregard for the populations to be served and the compassionate mandate which established and maintains the MCH program.

This reorganization fails to assure that programs will advance at the accelerated pace which is so vital. The Congress maintains a very active interest in maternal and child health programs, as manifested by the strong support Title V project extension received recently in both Houses. The maternal and child health program has been established for 38 years, and has continued through the years marked by distinguished accomplishment. The proposed reorganization is not a solution for the problems of the program, which admittedly may exist, nor would it provide improvement for the program.

The anxiety of the Congress with the new reorganization plan has intensified recently with press accounts regarding the resignations of Arthur Lesser and Dr. Gordon Macleod, two highly regarded program directors. Each official has stated that his resignation stems from the incompatibilty of reorganization and program objectives. Dr. Lesser has stated, "This is the first step in the elimination of categorical programs. It is another disregard for the intent of Congress."

In light of the seriousness of this issue, and the relative scarcity of information, it would be appreciated that your response include comment on these questions:

1. Why has no revised appropriations request been submitted to reflect the reorganization?
2. Are there plans to change program allottees as required by Section 36799 of the Revised Statutes and the HEW Accounting Manual Chapter 2–10 (6/26/67)?
3. How will each allottee be able to maintain supervision and accountability of personnel working in other offices?
4. Will each office have assigned staff to work exclusively on each of the programs, or will there be an "equivalent time" arrangement to assure that programs receive staff support proportionate to appropriations for direct program operations?
5. What recourse is available to the Assistant Bureau Director when offices are not responsive?
6. What are the long range plans since five of the programs are operating under one year extensions and maternal and child health program is under permanent authority? Is it the ultimate intention to phase out these six categorical programs?
7. Might the Department initiate this reorganization July 1, 1974, after the Congress decides upon the future of these categorical programs?
8. When will the details of the plan be available for public review?
9. Will comments on the plan be solicited and considered before it is initiated?
10. When might the Congress expect to be fully informed of administrative plans?
11. Will Congressional approval be sought?

The Committee on Ways and Means and, indeed, the entire Congress, would prefer to leave administrative organization and detail to the Executive. However, when administrative changes seem imminent, and these changes appear to run counter to the policy intent of the law, it becomes incumbent to the Congress, and even more so on the Executive, to engage in a dialogue which protects the intent of the Congress, maintains the integrity of the programs under discussion, preserves true administrative flexibility, and permits the Executive department in question to retain the confidence of the Congress in like matters.

It is our concern that the Department of Health, Education and Welfare administer all programs mandated to it by the Congress in the most efficient manner consistent with the program goals determined by the Congress. However, it is equally our concern that various categorical and other programs not be done to death through administrative legerdemain—a process that deprives programs of adequate fiscal and administrative support and strong professional leadership and then declares to the Congress that these starving and stumbling programs are clearly ineffective and surely inefficient, and should be terminated or blended with an even more amorpheous administrative unit, which itself is earmarked for destruction.

Your early response to both the specific questions and the larger philosophical one is appreciated. Advance communication through this informal means would seem to be preferable to repeated last minute legislative resuscitation by the Congress—action necessarily less well designed than is desirable.

Sincerely,

HUGH L. CAREY,
Member of Congress.

ATTACHMENT NO. 8

[Press Release: July 23, 1973—From Congressman Hugh L. Carey]

CAREY QUESTIONS POSSIBLE ILL-EFFECTS OF HEW REORGANIZATION PLAN

WASHINGTON.—Congressman Hugh L. Carey (D–N.Y.), was joined today hy 34 of his House Colleagues in requesting an explanation from HEW of an administrative reorganization that Carey believes will have very serious ill-effects on Maternal and Child Health Care programs throughout the Nation.

Carey's letter to Secretary Weinberger was prompted by the continued HEW assault on Health and other programs the Department is supposed to foster and see successful. The Congressman is increasingly dismayed at seeing the present Secretary of Health, Education and Welfare destroying progressive, human-needs programs passed by the Congress and administered in the recent past by such distinguished men as Abraham Ribicoff, Anthony Celebrezze, Wilber Cohen and John Gardner.

In a letter to HEW Secretary Weinberger, Carey asks, in eleven specific questions, for clarification of the Department's intentions with regard to Maternal and Child Health Care, and other categorical health programs being lumped together for purposes that may be "efficient", but which have been condemned by deeply worried health care professionals as destructive of the health care goals the Congress intended in creating them.

"The anxiety of the Congress with the new reorganization plan has intensified recently with press accounts regarding the resignations of Drs. Arthur Lesser and Gordon McLeod, two highly regarded directors of affected programs. Each official has stated that his resignation stems directly from the incompatibility of reorganization and program objectives. Dr. Lesser stated, "This is the first step in the elimination of categorical programs. It is another disregard for the intent of Congress."

The Congressman, further declared, "It is the concern of the Congress that the Department of Health, Education and Welfare administer all programs mandated to it by the Congress in the most efficient manner. However, it is equally our concern that various categorical programs not be done to death through administrative legerdemain—a process that deprives programs of adequate fiscal and administrative support and strong professional leadership and then declares to the Congress that these starving and stumbling programs are clearly ineffective and surely inefficient, and should be terminated or blended with an even more amorphous administrative unit, which itself is earmarked for destruction."

In closing, Carey stated that if the Department of HEW expects to regain the confidence of the Congress and retain authority in administrative reorganizations affecting policy goals set by the Congress, "Advance and thorough communication would seem to be preferable to repeated last-minute legislative resuscitation by the Congress."

The following Congressmen have added their names to the letter sent by Congressman Carey:

Bella S. Abzug
Joseph P. Addabbo
Mario Biaggi
Jonathan B. Bingham
Edward P. Boland
Frank J. Brasco
James A. Burke
John Conyers
James C. Corman
Ronald V. Dellums
Don Edwards
Dante B. Fascell
Daniel J. Flood
Donald M. Fraser
Michael Harrington
Robert W. Kastenmeier
Edward I. Koch
Peter Kyros
Lloyd Meeds
Patsy T. Mink
Robert N. C. Nix
Claude Pepper
Bertram L. Podell
Charles B. Rangel
Thomas M. Rees
Robert A. Roe
Benjamin S. Rosenthal
Dan Rostenkowski
William R. Roy
Fernand J. St Germain
Paul S. Sarbanes
Patricia Schroeder
Frank Thompson
Charles H. Wilson

Mr. ROGERS. Thank you, Mr. Carey, for an excellent statement. I think the points you have made are very well taken and I am sure this committee will adhere to your admonitions.

Mr. Preyer?

Mr. PREYER. Thank you, Mr. Chairman.

Your testimony is obviously deeply felt and delivered with full Celtic flavor and force. We appreciate it very much. Thank you.

Mr. CAREY. I might add that the infant mortality rate in Ireland is better than the United States right now. Maybe I will have to go back.

Mr. CARTER. Mr. Chairman, I have known the distinguished gentleman for many years, and I know he has known sorrow and trouble, and I regret that very much. I have sympathized with him over the years, and certainly sympathize with him about his wife, and I rejoice with him that she is better.

I want to say that I have always supported these programs, as I stated, previously with full funding. I have criticized HEW when they didn't bring up their funding on basic and applied research, and I will continue to do that. I happen to be affected in the same way the distinguished gentleman is, and I have been undergoing the throes of the same sort of trouble in my own family. As perhaps he knows, or should know, I am one of the men who worked hard to get the present cancer law into effect, supported it fully, completely, even more than, to a greater extent perhaps, many members of this committee.

I want to see the 20 centers established throughout the United States as the law requires, and I will fight to see that we have complete funding of this legislation. I think it is vitally necessary. I want to assure you that 57 percent of the people in my district recently reported in their questionnaire that they favored a form of national health insurance, and I don't want to see any woman denied in the country the privilege your wife has had for treatment for this condition which she has, or any youngster in our country denied the privilege of treatment for the dread diseases that my only son has at this time, and I shall support and continue to support legislation of this nature.

There is no one here that can say that I ever failed to support any health legislation which would be helpful since I have been on this committee, and I will continue to do it. However, I beg to remind the gentlemen here that according to his own fourth paragraph I was not wrong on the diseases. I believe we see in that paragraph that 700,000 people will die of heart condition.

I regret that our infant mortality rate is 550,000 per year, but I would correct—and I often make mistakes—but in this case I was not in error and I want to say this, that I hope and trust and pray that this committee which has worked together so long will not now adopt a partisan political attitude and attempt to castigate everyone who comes before the committee, and every elected official, no matter how good a man he might be. We can't legislate towards health as we attain political stances.

Health doesn't know politics, and sickness doesn't take a holiday. We must all work, regardless of what political party we belong to, for the health of our country, and I will pledge you that I will do that, and I am most happy to see you here because I regard you as one of the finest men, with one of the greatest hearts in this House, and you know it to be true.

Mr. CAREY. Thank you, Dr. Carter.

I do want to second your correction that you are quite correct that heart is at the over 700,000 killer level, and infant mortality is second at 550,000, but I fell into the common error on the Ways and Means Committee of what we might call the Mills syndrome. We sometimes extrapolate in terms of economies, and we have estimated that the cost of having 550,000 wanted children not born cost the country $90 billion in terms of life's earnings they would enjoy, whereas the extrapolated figure for heart is not possible to compute because most people suffer heart attacks not at the height of their earning capacity, but just at the time when they should relax and enjoy the fruits of life, so perhaps I was thinking in economic terms.

It cost us $90 billion because of the children who are not born, who could have participated in this society, and in that regard I do think the modest commitments we have made to maternal and child health would be a good economy if we invest in it.

Mr. ROGERS. Dr. Roy?

Mr. ROY. Thank you, Mr. Chairman.

Thank you, Mr. Carey, for your statement, and by the calculations that you last used I think with 14 children you have made a great economic contribution to the country. With six children maybe I have made about half the economic contribution to the country.

Mr. CAREY. Even our average is a little high.

Mr. ROY. Yes.

I wanted to ask you, is it your understanding that the PSRO service under Dr. Bauer will be primarily confining itself to policy matters and will be coordinating its administrative functions through the bureau of quality assurance?

Mr. CAREY. Well, this is precisely the kind of thing that has me upset. In our hearings conducted extensively on health insurance, again and again we had members of the profession, ranking officials in the American Medical Association, and independent physicians, come before us and tell us about the good experiences that the peer review organizations were having in getting fee-for-service schedules, and fee-for-service parameters worked out. These are necessary if we are going to have any kind of a national plan.

I can recall the chairman of the Ways and Means Committee, Mr. Mills, saying he had taken time during one of his visits home to sit in on a peer review session and found out it was far more exacting, say, than an appearance before the Congressional Ethics Panel, where you and I hope we will never go, but it was a demanding and effective system of agreed and reasonable fee-for-service programs that was being worked out in the field, and its implementation we were told would be very helpfully encouraged by the Department of HEW.

Now that statement was made by Secretary Richardson. He gave us some instinct, if you will, and hope that the PSRO's and the HMO's would be one of the things that would go into implementation gradually, carefully, and with extremely close monitoring to make sure the PSRO's were out there, according to guidelines prepared with the State and Federal Government, and with the professional organizations in such a way that we would know that the PSRO mechanism, HMO mechanisms, and others, were in place and working when we got ready to move downstream with health insurance.

Now if the PSRO's are going to be essentially agonized at the administrative level, and restudied, and not implemented and not promoted, then I say put the hope of the national health insurance plan

not in the year 1973, put it up in 1986 somewhere, because we are never going to get there. It would be too expensive, and it would lack the forethought and preparation necessary to make it effective. That is precisely what I am driving at.

Mr. ROY. I have been informed that there was a commitment given by the Administration to the Congressional Oversight Committees at the time of the conference that the PSRO operation would be conducted by a single office, and that the Director would be immediately responsible to the Assistant Secretary for Health. Was that your understanding at the time of the adoption of the legislation?

Mr. CAREY. Well, it was the best we could get as a guaranty. It was our hope that guidelines and regulations that would go to the States would be in force and effect by this time, and that together with the administrative, shall we say, upgrading of the programs would give us some assurance that the PSRO mechanism would be so much accustomed in the country that that one building block, shall we say, would be there for us to move ahead to make certain that sound professional services would be within reach at reasonable levels of compensation. If that has not been done, then we are moving right back into the gap of medicade-medicare, of forcing money into a flue without making sure that on the other end it is going to multiply and increase the effectiveness of medical care.

Mr. ROY. Again I thank the gentleman for his statement.

Mr. ROGERS. Thank you so much. Mr. Carey, the committee is grateful for your interest and for the very excellent statement you have given today.

Mr. CAREY. Thank you, Mr. Chairman.

Mr. ROGERS. Our next witness is Dr. Charles C. Edwards. He is accompanied by: John S. Zapp, D.D.S., Deputy Assistant Secretary for Legislation—Health—HEW; Harold O. Buzzell, Administrator, Health Services Administration, HEW; Robert Laur, Ph. D., Acting Administrator, Health Resources Administration, HEW; Kenneth M. Endicott, M.D., Acting Director, Bureau of Health Resources Development, Health Resources Administration, HEW; and David T. Smith, Executive Director, National Center for Toxicological Research, Food and Drug Administration, HEW.

STATEMENT OF DR. CHARLES C. EDWARDS, ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY DR. JOHN S. ZAPP, DEPUTY ASSISTANT SECRETARY FOR LEGISLATION (HEALTH); HAROLD O. BUZZELL, ADMINISTRATOR, HEALTH SERVICES ADMINISTRATION; ROBERT LAUR, PH. D., ACTING ADMINISTRATOR, HEALTH RESOURCES ADMINISTRATION; DR. KENNETH M. ENDICOTT, ACTING DIRECTOR, BUREAU OF HEALTH RESOURCES DEVELOPMENT, HEALTH RESOURCES ADMINISTRATION; AND DAVID T. SMITH, EXECUTIVE DIRECTOR, NATIONAL CENTER FOR TOXICOLOGICAL RESEARCH, FOOD AND DRUG ADMINISTRATION

Dr. EDWARDS. Thank you, Mr. Chairman.

I would like to set the record straight before I get started with my statement. First of all, I think Mr. Carey was totally unjustified in trying to compare infant mortality and heart disease. I think, first of

all, you have to recognize that the infant mortality figure is much, or a significant amount of the infant mortality statistics representing heart diseases. So in a sense you are comparing apples and oranges, so this doesn't stand scrutiny.

The other point I would like to make is I think Dr. Roy's remarks were totally unjustified. First of all, it was my understanding that this hearing was held to discuss the reorganization. So far we have discussed Watergate, we have discussed impounding, and we have discussed the administration's budget, none of which has anything specifically to do with our reorganization.

I think that the group that we put together to develop the reorganization plan did an excellent job. As a matter of fact, I would challenge Dr. Roy to submit our reorganization to any group of management people that he would like to. They may not totally agree with all aspects of it, but I think you can't say it was motivated by political considerations. I think it is obvious that we have to take into consideration the administration's proposed budget. These programs that the administration were going to phase out were no longer going to be, we had to make sure that the organizational structure that we were going to put them in made sense, but nevertheless I say it is a good reorganization. I think it will stand scrutiny by the experts, and to attempt to politicize it, or make it a Watergate or impounding issue is not appropriate.

Mr. Chairman and subcommittee members, I am glad to be here today at your request to discuss the reorganization of the health component of the Department of Health, Education, and Welfare. As you may know, we met with congressional committee staffs to go over this matter last Friday evening.

I would like to discuss with you today in somewhat general terms why we felt a reorganization was necessary in this area, how we studied and evaluated what should be done, and what the outcome was. Then my colleagues and I will try to answer any specific questions you may have.

WHY REORGANIZE?

The term reorganization seems to connote to many people bureaucratic reshuffling for no apparent purpose. Yet the word has a respectable sense in the world of business and finance as a restructuring of an organization to cure or avoid failure, or to incorporate new elements, serve new markets, meet new problems.

Mr. Chairman, we are not reorganizing merely for the sake of reorganizing. We are trying to use what has been learned from experience to reverse prior failures. We are trying to incorporate into our overall health concern relatively new elements, such as third-party financing and quality control. And we certainly have a plethora of urgent problems.

A STRONG VOICE FOR HEALTH

Over the last five or more years, this Department has simply not been in a position to speak with singular authority about the overriding health problems facing the country or about the means of solving them.

Instead of one voice we have had an NIH voice, an FDA voice, several HSMHA voices, each with its own message and its own assessment of problems and proposals for dealing with them.

The effect of these divided responses has been that we have had less impact on policy development or the shaping of budgets and programs intended to carry out policy than we could have had with a united effort. Very good staff work and sound professional input has been weakened or made ineffective by fragmentation and even inconsistency among the multiple "Health" spokesmen. We have been wasting talent. And what is worse, we clearly have not made the kind of progress toward solving health problems that the White House, the Congress, and the public have every right to expect.

I'm not suggesting that simply restructing the Department's health programs will suddenly give us a strong and effective voice in the development of national health policy. But I am convinced that our efforts to carry out the role of policymaking and implementation assigned to us by the Secretary would have been seriously hampered as long as functions that logically fitted together remained scattered among the three health agencies.

For if we are going to discharge our leadership role as the Federal health agency, we must first mold ourselves into the organization which can, in fact, assume that role.

REGIONAL EFFECTIVENESS

There is another important activity that we have set in motion concurrently with the reorganization effort. It has to do with decentralization. However, the decentralization has no direct bearing on the health reorganization activity.

I am aware of your interest and concern of the trend toward placing increased operating responsibility and decisionmaking authority in the regional offices. We are in the final stages of developing a proposal for realinement of our regional offices' health activities. While I obviously am not in a position today to express any conclusions as to how those offices will ultimately be organized, I can assure you of our intent to take full advantage of the potential they afford in implementing national health programs. We are striving to get them in a position to focus their efforts on the things they can do best, such as direct technical assistance and consultation for State and local programs, monitoring compliance with established criteria and applying, in the field, general health surveillance techniques. Their advice on policy and suggestions for programmatic improvement will be communicated directly to me through the heads of the 10 regional health offices.

REDIRECTION OF THE OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

Over the past 4 years, one of the issues that has become most obvious to me has been the need to have a strong and forceful voice for the Assistant Secretary for Health. An office with the talent and resources to provide the necessary health leadership for the Department was essential. This we are providing now.

It is not my intention that our office will involve itself in the day-to-day operations of the health agencies. We have, however, tried to build into the Office of the Assistant Secretary for Health the necessary capacities to guide Department health activities in the planning and conduct of operating programs, to assist in management and administration, and to make certain that policy is being carefully developed and effectively implemented.

Toward this objective, we have restructured the OASH staff. On July 12, a statement of organization and function for the Office of the Assistant Secretary was published in the Federal Register. Basically, the new structure consists of four major offices:

Administrative management, policy development and planning, program operations, and regional operations.

There are seven special staffs, several of which have been mandated by law: The Professional Standards Review, which we are all interested in is one. Professional Standards Review is, in fact, in my office; International Health; Population Affairs; Drug Abuse Prevention; Nursing Home Affairs; Executive Secretariat; and Public Affairs.

Mr. Chairman, with your permission I shall insert the balance of my prepared statement into the record and we are prepared to answer any questions you or the other committee members may have. Thank you.

[The balance of Dr. Edwards' prepared statement follows:]

Reorganizing the Health Agencies

Practically since its inception it has been evident to many, myself included, that HSMHA was not an administratively viable organization. Shortly after assuming my present responsibilities I made a recommendation to the Secretary that a study of HSMHA be undertaken. The Secretary concurred and the study was carried out by a Task Force headed by Mr. David Smith who is here with us today and who, I'm sure, will be happy to answer any questions you may have regarding that effort.

Based largely upon the information and recommendations presented in the Task Force Report, a reorganization plan was developed, the broad outlines of which are quite definite, though many of the details concerning specific programs and specific functions are still being worked out.

In essence, what we have done is to group the Department's health programs into five agencies each of which now has a clear and coherent mission, and each of which now reports directly to the Assistant Secretary.

As you know, the Health Services and Mental Health Administration has been abolished; its various programs have been assigned to NIH, to CDC—which has become a free-standing agency, and to two new agencies—The Health Services Administration and the Health Resources Administration.

The FDA is substantially unaffected by this realignment.

As noted, The Center for Disease Control, formerly part of HSMHA, has become a separate agency and has assumed, in addition to its established activities in the area of preventive health, administrative control of the functions being carried out by the Bureau of Community Environmental Management, and the National Institute for Occupational Safety and Health.

There are two major changes affecting NIH. First, the National Institute of Mental Health has temporarily been transferred from HSMHA to NIH. This move obviously entails adding research activities to those that the NIH already supports in such areas as cancer and heart disease. The NIMH, however, is engaged in service delivery programs relating to mental health, alcoholism and drug abuse. Therefore, we have to take a hard look at the appropriateness of having NIH, which is essentially a biomedical research organization, deeply involved in the delivery of health services. I feel that we have to make a careful assessment of the NIH research mission and determine to what extent NIMH service activities may add to or detract from the fulfillment of that mission. To do this, an NIMH study group was formed and we are expecting a final report from that group very soon, and will certainly plan to keep the Congress fully informed as to the direction we are taking with respect to the NIMH activities.

THE NEW HEALTH AGENCIES

Health Services Administration (HSA)

The new Health Services Administration consolidates programs which finance or directly support the delivery of health care services. These programs are supported through a variety of mechanisms, including formula and project grants, contracts, assignees in the field, and direct Federal assistance for beneficiary care. The agency includes the service delivery components of HSMHA—Family Planning projects, Neighborhood Health Centers, Migrant Health projects, Maternal and Child Health projects and formula grants, 314(d) Public Health Services formula grants, National Health Service Corps, Health Maintenance Organizations, and the direct care activities: Indian Health Service and Federal Health Programs Service. It also includes operational functions of the Professional Standards Review Organization program, pursuant to policy direction from the Office of the Assistant Secretary for Health, the Medical Care Standards Program from the Community Health Service, and the Kidney Disease Treatment Program.

The agency is specifically designed to:

Provide and finance the delivery of health services through grants, contracts and direct delivery.

Promote the integration of service delivery with public and private health financing programs.

Assure quality and contain costs of services provided through the public financing programs.

Within HSA there are four major components: Indian Health Service and Federal Health Programs Service which remains essentially unchanged; and the new Bureaus of Community Health Services and Quality Assurance. These programs follow the decentralized approach toward which we have steadily moved in the past four years. Indian Health activities have been carried out in Indian Health Service units, through area offices, and contracts with local health resources. Similarly, while the Public Health Service Clinics and Hospitals receive administration from the national level, their entire focus has been upon service delivery through their facilities and through contracts with local resources. During the last three years appropriate grant programs, related decision making and supporting manpower have been effectively regionalized achieving the desired movement of basic administration closer to the delivery site.

Bureau of Community Health Services

This Bureau incorporates five organizational units formerly operating in the Health Services and Mental Health Administration. They are the Community Health Service, Maternal and Child Health Service, National Center for Family Planning Services, National Health Service Corps, and Health Maintenance Organization Service. These five units each have categorical grant or community assistance program responsibilities and, thus, have appropriately been restructured under a single Bureau.

As we have indicated certain functions are vital to an accountable, decentralized operation. It must be possible to identify what projects and activities are expected to achieve to meet legislative intent and to effectuate Administration initiatives. It must then be possible to allocate adequate resources for the achievement of identified goals. Finally, there must be established well-understood means by which progress is measured. The proposed structure of the Bureau of Community Health Services reassembles resources in ways which allow these functions to be carred out fully and effectively.

Identifying what is needed in the program areas of Maternal and Child Health, National Health Service Corps, Neighborhood Health Centers, Family Planning, Health Maintenance Organizations and Migrant Health will be Assistant Bureau Directors, each with a core staff. It is here that responsibility rests for expressing clear program commitments and goals, for making them known to decentralized staff, for allocating resources, measuring performance and assuring that needs are met. The Assistant Bureau Director staff in each program area will draw upon all staff elements through orderly, thorough work planning and assignment processes. They will be the primary points of accountability.

Regulations, guidelines, policy statements, and performance measurements will be the full time concern of a substantial knowledgeable staff in an Office of Policy Development. In like manner, experts in information systems, project and program analysis and assessment will be brought together in an Office of Monitoring and Analysis, and the expert professional and technical guidance required by these offices (and by Regional Staff) will be provided through Offices of Clinical, Health Services Financing and Organization Development. The important point that I

would like to stress, is that even with these functionally-designated offices, there will be groups of individuals working in categorical program areas not unlike what they are presently doing. However, management will have more flexibility in assigning critical manpower resources to programs with the highest priorities. I think the best example I can give of this is the system we have established and found successful at FDA.

Bureau of Quality Assurance

The Bureau of Quality Assurance was established as the National focus for assuring accountability to health care consumers of the quality and costs of health care services. Along with BCHS, this Bureau will emphasize efforts to achieve the integration of health service delivery with private financing systems so as to assure Federal responsiveness to the needs of individuals and groups in all segments of society. BQA is expected to be concerned with these quality questions which relate to existing health service financing programs for the purpose of developing standards and mechanisms which effectively ensure implementation of quality assurance activities to benefit the beneficiaries of financing programs as well as—almost assuredly—much of the rest of the population. Furthermore, it represents a wise preparatory process for any form of National Health Insurance.

This Bureau will have four major areas of responsibility—professional standards review organization program, utilization review, medical review, independent professional review, and the continuing professional development of health and safety standards for providers of services under Medicare and Medicaid. Activities include developing, directing and administering policies, criteria and other program conditions as they relate to BQA major areas of responsibility.

Health Resources Administration (HRA)

The mission of the Health Resources Administration is to provide a national focal point for the identification, deployment, and utilization of the physical, financial, and personal resources to achieve the best possible health services for the people of the United States. Its activities should result in more effective and efficient use of the Nation's health resources in furtherance of our ultimate goal of having high-quality health services available to all people in all parts of the country.

Through its programs, the Health Resources Administration already:

Conducts and supports analyses, research, developmental activities, technical assistance programs, and informational services needed to support intelligent planning for the Nation's health system. Through the National Center for Health Statistics, it collects, analyzes, and disseminates data on vital and health statistics. It also gathers and disseminates information on the health status of our people, and on health expenditures and the utilization of health resources in the Nation.

It develops and evaluates improvements in the standards for health facilities and health services.

It supports the recruitment, training, and education of health services personnel.

It provides leadership to, and helps the development of Federal, State, and local health planning activities. And this newly-organized Administration maintains a systematic look at the Nation's health establishment through the use of management studies, cost and benefit analyses, performance studies, and evaluation.

HRA will be a primary source of technical and professional assistance to my office in developing and analyzing health policies.

Basically, the Health Resources Administration is made up of three major units as follows:

National Center for Health Statistics

This Center will include all the program functions formerly located within the National Center for Health Statistics, and those associated with other baseline data systems and data research efforts in health—such as the Federal-State-Local Cooperative Health Statistics System, and the Manpower Data Systems of BHME. We are also evaluating whether other health related data collection activities should be incorporated into or otherwise adapted for increased compatibility with the NCHS function. These include the Abortion Reporting System (CDC); the Health Services Scarcity Area Identification Program (CHS); the Occupational Hazard, Injury, and Illness Survey (NIOSH); and the national baseline data systems of the NIMH.

The Center collects, analyzes, and disseminates data on vital statistics and on many other areas of health, including the physical, mental, and physiological

characteristics of the population, illness, injury, impairment, the supply and utilization of health facilities and manpower, and on changes in the health status of people. It also administers the Cooperative Federal-State-Local Health and Vital Statistics System, and stimulates and conducts basic and applied research in health data systems and statistical methodology.

This litany of functions does not, I'm afraid, carry the impact it should in underlining the importance of the evolving NCHS program. We are attempting to create an accessible, central, and uniform health intelligence capacity that has not heretofore existed. We have not had to date adequate usable information available to meet the needs of health planners, health administrators or health legislators. What we are now systematically putting into place is a capacity which can provide us, the Congress, and all those concerned with health in States and communities with the information we all urgently need to accomplish even our most modest goals.

Bureau of Health Resources Development

The Bureau of Health Resources Development monitors the utilization, distribution, and development of human and physical resources in the provision of health services to the people of the United States.

The Bureau is responsible for the administration and support of programs to meet health manpower requirements through education and training and to give general support to institutions engaged in education and research in certain areas in the health field. It encompasses grant and loan programs and other operations which promote and support the extension and improvement of the educational process to increase the supply and improve the quality of health manpower. More specifically, its programs promote and support manpower education, in-service training, continuing education, and specialized activities designed to ameliorate the effect of geographic and specialty maldistribution. Most of these functions were formerly in BHME.

The Bureau also is responsible for developing DHEW programs for the improvement and extension of comprehensive health planning at all levels of activity. This planning depends heavily on a solid data base, clear community health objectives, skills in planning disciplines, and a consistent State/local response to planning decisions. Resource allocations is a high CHP priority as it extends its efforts toward cost containment, sensible distribution of services, and more efficient delivery systems. Manpower and facilities, which absorb huge amounts of government and private funds, should be subject to extraordinary attention in planning at all levels of government.

Also placed within the Bureau are all authorities for facilities construction, including the Hill-Burton program.

As part of its development of data on the utilization, distribution, and need for health manpower, the Bureau will have developed periodic projections of manpower and facility needs for the use of DHEW agencies and other governmental units. It also will serve as a clearinghouse for information on health manpower needs, resources, education, training, and utilization.

Bureau of Health Services Research and Evaluation

The Bureau of Health Services Research and Evaluation conducts and supports analyses and research on the organization, delivery, and financing of health services. It also supports the development of new approaches to improve the distribution, utilization, and cost effectiveness of health services and resources.

The Bureau has responsibility for development of the overall health services research strategy of DHEW. In addition to performing a primary function of health services research and evaluation, it also will coordinate all such research activities within HRA and across the other health agencies.

This Bureau also administers the Regional Medical Programs Service and the Emergency Medical Service program, both of which are designed to demonstrate and evaluate, albeit in somewhat different areas of focus, improvements in health services, and to promote development of innovative health service systems.

Long-term care activities previously scattered throughout HSMHA now are incorporated into a single long-term care program in the Bureau of Health Services Research and Evaluation. A major responsibility will be the continued implementation of the President's Nursing Home Improvement Program which seeks to improve the quality of life and health care in the Nation's nursing homes. The Nursing Home Ombudsman Demonstration Projects in this new Bureau are evaluating the use of a patient advocate in resolving grievances of nursing home

patients. A nationwide network of training programs is increasing knowledge and improving skills of nursing home personnel.

CONCLUSION

Any new organization has to go through a "shake-down" period of adjustment. Those established or restructured in our current endeavor will be, I'm certain, no exceptions. We will very likely have to adjust and change various parts or responsibilities of this reorganization plan to do the job which needs to be done. We intend to keep the Congress and this Committee informed of significant changes, just as we shall keep you informed of our progress.

Thank you. My colleagues and I will be happy to answer any questions you may have.

Dr. EDWARDS. Mr. Chairman, I would like to put these charts up on the easel and give you a brief overview of the structure itself, if that would meet with your approval.

Mr. ROGERS. Without objection, that will be done.

Dr. EDWARDS. This is Mr. Buzzell, as you know, who came to the Department with the understanding that he would supervise the reorganization and then would become head of the new Health Services Administration.

Mr. BUZZELL. Mr. Chairman, I will take just a moment to run through these charts. One of the major considerations in the reorganization was to not only strengthen Dr. Edwards office, but also to concern ourselves with control in order to insure that Dr. Edwards was able to carry out a major policy role without becoming involved in the day-to-day activities.

In connection with the PSRO effort this is precisely what we are doing. We are providing Dr. Edwards with the specialized components in his office, major policymaking and major operational activities for fulfilling the program objectives. But with five agency heads reporting to him, with four major operational components in his own office, and with seven major specialized staff groups, it is quite important, to make sure that we in the agencies can fulfill the direction he provides us. That is what we are doing in the Bureau of Quality Assurance.

We think that organizationally we have set up a structure that makes us more responsive. Now the old HSMHA, which I had the fortunate experience to run for 2 or 3 months, I believe, was an impossible task for my predecessor or myself, or anyone else to manage. There were 17 major programs to manage, 35 to 40 people reporting directly to the Administrator, plus all of the regional health people. This is the basic principle behind the reorganization.

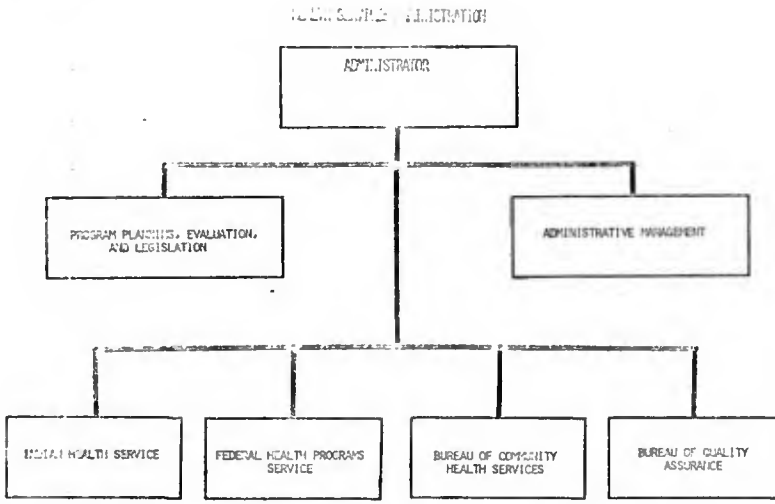
HEALTH SERVICES ADMINISTRATION

Mission: Provides and finances the delivery of health services through grants, contracts and direct delivery; promotes the integration of service delivery with public and private health financing programs; and assures quality and contains costs of services provided through the public financing programs.

Functions: Reviews the appropriateness of care received in terms of cost, quality, and effectiveness; administers the grant-supported health service delivery programs to maximize the provision of services and control costs; prepares health service programs for support through third party financing by strengthening their management capability and ensuring they meet acceptable standards for reimbursement and quality; supports the development of health maintenance organizations and other improved methods of health care delivery; improves access to care to residents of health service scarcity areas; and provides health

services to specific Federal beneficiaries while facilitating conversion of these activities to support through financing programs.

Mr. BUZZELL. The Health Services Administration's mission is to provide and finance the delivery of health services through grants, contracts, and direct delivery. It has these following functions: Review the appropriateness of the care received in terms of cost, quality and effectiveness; administer the grants in health service delivery programs; prepare health service programs for support through third-party financing; support the development of HMO loans and other improved methods of health care delivery, and improve access to care of residents of health service scarcity areas; and finally, provide health services to specific Federal beneficiaries while facilitating these activities to support through financing programs.



Mr. BUZZELL. It is against that mission that we have created our organizational structure, and it is against that mission that we have assigned the proper teams that fit with it.

Very quickly, as you can see, the Health Services Administration has four bureaus: the Indian Health Service; Federal Health Program Service; Bureau of Community Health Services; and finally the Bureau of Quality Assurance.

Dr. EDWARDS. I want to emphasize, Mr. Chairman, as you can see, there is nothing in this organizational chart that would indicate the phasing out of any program on our part. The Federal Health Program Service is in fact the Public Health Service hospitals.

Mr. BUZZELL. In that regard, that Federal Health Program Service has not been recognized. Its people have not been reassigned. The structure remains the same waiting for our implementing direction. Two major differences, of course, are the Bureau of Community Health Services and the Bureau of Quality Assurance. The Bureau of Community Health Services includes: the National Center for Family Planning Service, Maternal and Child Health Service, Community

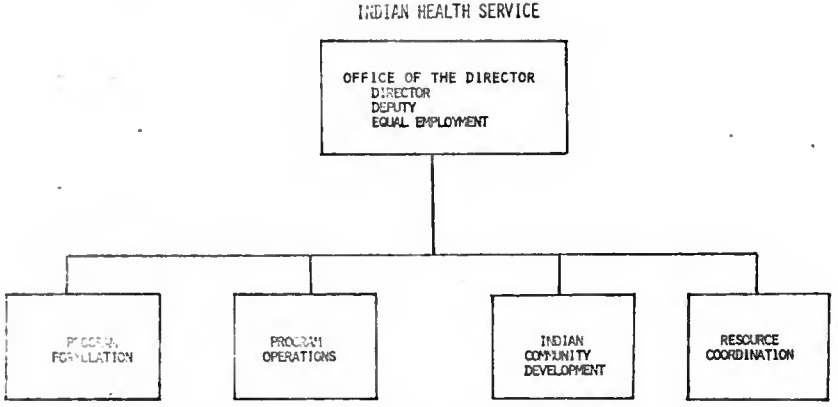
Health Service, and the National Health Service Corps, and finally the Health Maintenance Organization Service.

Again, the same individuals are working on these programs that were working there before. The same number of man-years of effort are being applied. No reductions have been made or reassignments of staff in order to phase down the program or to subdue a program.

Indian Health Service

Mission: Assures a comprehensive health services delivery system for American Indians and Alaska natives with sufficient options to provide for maximum tribal involvement in meeting their health needs.

Functions: Serves as the principal Federal advocate for Indians in the health field; provides comprehensive health care services, including hospital and ambulatory medical card, preventive and rehabilitative services, and development of community sanitation facilities; facilitates and assists Indian tribes in coordinating health planning through Federal, State, and local programs, in operation of comprehensive health programs, and in health program evaluation; and assists Indian tribes in developing their capacity to man and manage their health programs.

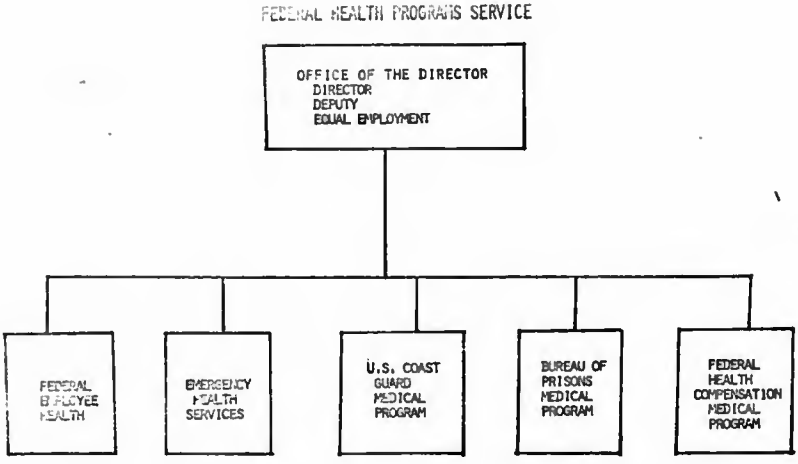


Mr. Buzzell. The Indian Health Service I will not go through. It has not been changed. It is important to note that we have over 7,000 employees primarily all of whom are out in the field. Something on the order of 100 are here in Washington. It continues under the management of Dr. Emery Johnson.

Federal Health Programs Service

Mission: Provides comprehensive medical care to all designated beneficiaries of the Public Health Service.

Functions: Provides comprehensive direct health care for designated Federal beneficiaries and selected community groups; provides occupational health care and safety services for Federal employees; coordinates national planning, advance preparation, and logistic support for emergency health services; plans and develops training for health services personnel; and directs the conduct of intramural clinical and health services research.



Mr. BUZZELL. The same thing is true with the Federal Health Program Service. Its mission is unchanged. It continues under the direction of Dr. Robert Streicher. Again the major management problem is maintaining the hospitals. Its organization chart is the same. We have not reorganized it.

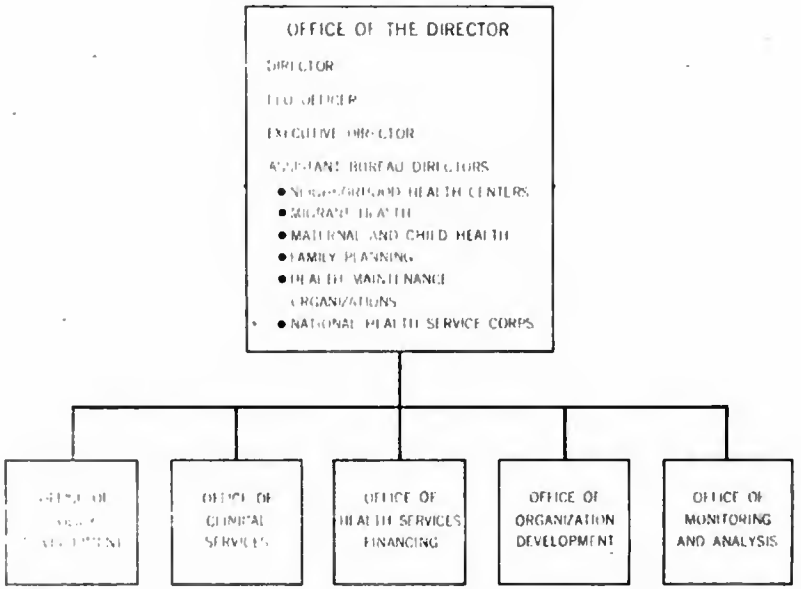
BUREAU OF COMMUNITY HEALTH SERVICES

Mission: Serves as a national focus for efforts to improve the organization and delivery of health services in the context of the major health care financing programs.

Functions: Facilitates the development of locally based programs of health services delivery; initiates activities which provide alternate methods of health service delivery and health maintenance; enhances the capacity of existing health service programs for full participation in the major public health financing systems—medicare and medicaid; administers programs providing specific services and/or specific populations including family planning, maternal and child health care and migrant care; directs programs which assure access to health care in underserved areas; and improves quality and contain costs of services provided in grant-initiated health service delivery programs.

Mr. BUZZELL. The Bureau of Community Health Service, it is important to note, has a mission to serve as a national focus for efforts to improve the organization and delivery of health services in the context of major health care financing program. Its function is to facilitate the development of locally based programs of health services delivery; initiate activities which provide alternate methods of health service delivery and health maintenance; enhance the capacity of our existing health service programs for full participation in the major public health financing systems, primarily medicare and medicaid; administer programs providing specific services for specific populations, including, of course, family planning, maternal and child care, and migrant care; directs programs which assure access to health care in underserved areas; and finally to improve the quality and contain cost of services provided in grant-initiated health service delivery programs.

BUREAU OF COMMUNITY HEALTH SERVICES



Mr. BUZZELL. Now the Bureau of Community Health Service provides these six major programs with associate Bureau directors, who will have program responsibility for their programs and who in turn will be assisted by division chiefs in five functional areas. These programs are quite similar in nature and the important management assistance and technical assistance activities to support the program are pretty much identical regardless of the program, and that will be the responsibility of these divisions' directors. The Office of Policy Development, Office of Clinical Services, Office of Health Services Financing, Office of Organization Development, and Office of Monitoring and Analysis, will be tracking the performance of the program.

Dr. EDWARDS. Mr. Chairman, we have been, of course, as you know, criticized for doing away in this plan with the categorical approach to programs. I think that is wrong. Although the office down below the Office of Policy Development and so forth, although they are functionally oriented, nevertheless there will be groups in each of these offices that will be providing categorical services to categorical programs.

The important thing is it gives management at least some flexibility in terms of distributing some of his manpower strength to programs that happen to be very high priorities at the moment. For instance, in Food and Drug, if we have a Bon Vivant, we organize all of our resources to meet this problem. I think this gives managerial flexibility and does not do away with the categorical approach to certain programs.

Mr. ROGERS. For instance, who will staff this Office of Policy Development?

Mr. BUZZELL. The Director of the Bureau of Community Health Services.

Mr. ROGERS. I know, but with what people?

Mr. BUZZELL. The current staffing as we envision it for this office will be a staff of specialists who have been doing that work in the programs before. These same individuals who have been preparing guidelines and regulations and whom I would describe as the technical experts for those programs.

Mr. ROGERS. In other words, from that office you are going to develop your policy for neighborhood health centers, migrant health, family planning, and national health service corps?

Mr. BUZZELL. What we will be doing is making sure that we have provided the field with the guidelines and the regulations to implement the policy that is being provided.

Dr. EDWARDS. Again, that doesn't mean that we won't have individuals in each one of those offices that are working in the maternity and child health field, and RMP, and so forth. The critical ingredient here is that each of these programs, heretofore their long-range planning, their policy development, et cetera, have all been done in the context of that program and that program alone.

You can't talk about maternal and child health without talking about neighborhood health programs. You can't talk about neighborhood health programs without talking about RMP. The problem is that they have been so categorical that there has been no relationship among programs, and until we get these programs trying to work for the development of a better total health system we are not going to come to grips with our problems.

Mr. BUZZELL. The major policy that you would be concerned with, Mr. Chairman, will be done by the assistant bureau director. This is more in the way of technical assistance in terms of doing the draft work, the design work, and drafting of regulations and guidelines.

Mr. ROGERS. What about health services financing? What will that office do?

Mr. BUZZELL. The fiscal systems work in helping a neighborhood health center or in helping our regions to become more adept at developing an accounting system, for example, for one of the outplaced centers. This entire group is basically a management assistance and technical assistance group. Again, it is the policy of staff work being done at the level of the bureau director and the assistant bureau directors under him.

Mr. ROGERS. Well, how does the health maintenance organization, for instance, fit in with migrant health? I would think the two would almost be at odds because it seems to me the health maintenance organization must be for people who are able to pay, where migrant health is not necessarily that. So how does the financing expert——

Dr. EDWARDS. Not necessarily. Our health maintenance organizations, if they are any good, in my judgment, are programs that are across the board. They will handle not only those who can afford to pay but those who cannot.

Mr. ROGERS. Well, how are they going to do it? You can't keep an HMO going unless people can pay for it.

Dr. EDWARDS. Well, there is medicare and medicaid.

Mr. ROGERS. Well sure, but there has got to be payment.

Mr. BUZZELL. Correct, but the constituency served is different in these programs.

Mr. ROGERS. What I am concerned with is where does the expertise come from? Are you just going to stick them all in one office together? Is that what you are doing?

Mr. BUZZELL. I am sorry, I didn't understand the question, Mr. Chairman.

Mr. ROGERS. What I am trying to find out is will you have a person in the Office of Health Services Financing who is an expert from HMO?

Mr. BUZZELL. Yes.

Mr. ROGERS. One from Migrant Health?

Mr. BUZZELL. Yes. This staff of experts are currently residing in the six categorical programs that we are putting in here.

Mr. ROGERS. So you are just pulling them together.

Dr. EDWARDS. We are pulling them together. To develop some of the financing procedures and systems for one program is not a great deal different from another program, but nevertheless within the Office of, for instance, Health Services Financing there will be categorical groups, but the overall Director of that Office will also be directing the overall health service financing of all of the categories under his jurisdiction.

Mr. BUZZELL. These individuals bring both program experience and technical experience in their functional area to this office.

Mr. ROGERS. What about organization development? The organization for HMO, for instance, will be quite different from that of National Health Service Corps.

Mr. BUZZELL. That is correct, but some of the management problems from the National Health Service Corps or maternal and child health project are very similar, and again, these are individuals who have management organization kinds of capabilities, and also have program experience having worked in these programs before. I think it is important to point out that this organization really represents the staff from the programs that we had aligned separately before.

Dr. EDWARDS. I think another important point to be made, Mr. Chairman, is that if we don't go this route, then the other alternative is to have this kind of organizational chart for each and every categorical program we have in the Department of Health, Education, and welfare, and managerially it doesn't make sense. It doesn't make sense from the point of view that we do not have and cannot get that kind of capability. We have to begin to utilize our manpower resources so that the good people are being, at least to a degree, being utilized in more than one program. And I think to say we should have this kind or organizational chart for each and every program is just inconsistent with good management.

Mr. ROGERS. I don't know that you need it for every one to that extent, but from what I understand, you are keeping the same people but you have just regrouped them. So I don't know that we are gaining a lot from it.

Dr. EDWARDS. This limited group of people doesn't have to grow and grow, but they can contribute their expertise in some cases to more than one program.

Mr. BUZZELL. That is right. Many of our people are in fact functional specialists, and I think that the opportunity for them to participate as a functional does foster their individual growth.

Mr. ROY. Will the gentleman yield?

Mr. ROGERS. Yes.

Mr. ROY. With the decentralization, isn't there also the very real possibility that instead of reduplicating this structure as you would with categorical programs, you will be reduplicating this structure at the regional level? Aren't we trading one reduplication for another?

Dr. EDWARDS. First of all we haven't devised a definite plan for the regions yet. The point that we would make is that this organizational plan in our judgment stands no its own merits regardless of what the regoinal plan looks like. I think there is some reason to believe, or it makes some sense in the regions, to get at least partially away from everything being categorical. I think that this particular concept is good here and it is good in the regions.

Mr. ROGERS. Of course I think that what we are concerned with is how we are going to trace and account for what happens.

Dr. EDWARDS. You are going to get an accounting from that Assistant Bureau Director. We are placing him in the direct line management of this whole operation, and if you are having problems with a neighborhood health service program, it is obvious where you go. You go to the Assistant Bureau Director for Neighborhood Health Centers. He is the guy accountable to you and the Director and to our Office and the Secretary.

Mr. ROGERS. But I am not sure if he is going to be able to break it out categorically. He may say, "I can only do something functional."

Dr. EDWARDS. No, no. Not at all. He has the responsibility for getting certain things done in Migrant Health or Neighborhood Health Centers and if he doesn't get it done he is held responsible for it. He also has people in these boxes that are going to be responding to the particular program needs of his program.

Mr. ROGERS. So that still will be a categorization of the programs.

Dr. EDWARDS. There will be all the categorization, Mr. Chairman, that you and the Congress need, because you will absolutely know where to go. If the results aren't there, then that is another issue. I mean if we are not producing what you want produced, that is another issue, but you won't have any problems in my judgment, nor will I have any problems. As the HEW head of Health, I won't have any problems finding out where I should go when you ask me certain questions about certain programs.

Mr. ROY. Will the gentleman yield further?

Mr. ROGERS. Yes.

Mr. ROY. The Assistant Bureau Director reports to the Office of the Director of the Bureau of Community Health Services, who reports to you, Mr. Buzzell, as Director of Health Services Administration, and then you in turn report to Dr. Edwards.

Mr. BUZZELL. That is correct.

Mr. ROY. Is this really closer to the top, Dr. Edwards, than he was before? Now I confess I am not that familiar with the present organization.

Dr. EDWARDS. Bob, you might show him the old HSMHA chart.

Mr. BUZZELL. We did have a Director, for example, for HMO, who in turn would report to an Associate Director, and we had it located under the developmental cluster, who in turn reported to the Administrator of his branch. This is the old HSMHA organizational structure, and it only showed two major components, and as I indicated it does include, for example, the Center for Disease Control, and with

that kind of responsibility in HMO, other programs were deprived, leadershipwise, through no fault of any individual.

BUREAU OF QUALITY ASSURANCE

MISSION

Serves as the national focus for assuring accountability to health care consumers of the quality and costs of health care services.

FUNCTIONS

Facilitate and coordinates the quality assurance and utilization requirements of public financing programs, titles XVIII and XIX of the Social Security Act.

Assures accountability to consumers by assisting providers, provider groups and health insurance programs to adopt improved quality and cost controls.

Directs and coordinates the application of quality and cost controls in federally sponsored direct and grant-supported health services delivery programs.

Develops and coordinates data and data systems requirements for quality and cost control.

Develops, tests, and evaluates improved methods and techniques of quality and cost control, including methods for ambulatory, long-term health care settings, and total community systems of care.

Evaluates the impact of quality and cost controls on health status and health costs.

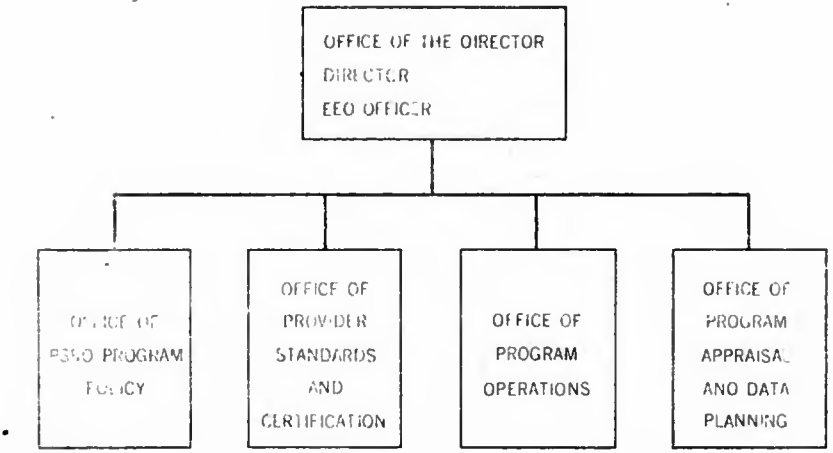
Assists in the development, application, and evaluation of standards for health care provided under titles XVIII and XIX.

Mr. BUZZELL. I have just two more charts. The Bureau of Quality Assurance represents in effect our first organized effort to provide a focus for assuring accountability to health care consumers of the quality and costs of health care services. The functions, very quickly, facilitate and coordinate the quality assurance and utilization requirements of public financing programs. Titles XVIII and XIX assure accountability to consumers by assisting providers, provider groups, and health insurance programs to adopt improved quality and cost controls; directs and coordinates the application of quality and cost controls in federally sponsored direct and grant-supported health service delivery programs; develop and coordinate data systems requirements for quality and cost control; to develop tests and evaluate improved methods and techniques of quality and cost control; evaluate the impact of quality and cost control on health status and health costs; and finally assists in the development, application, and evaluation of standards for health care provided under titles XVIII and XIX.

Mr. BUZZELL. This represents a major endeavor to be responsive to the policy, and responsive with providing Dr. Edwards with the kind of capacity he needs to carry out the policy role. Very quickly, this contains an Office of PSRO program policy, residing at the level of Dr. Bauer directly in the Office of Dr. Edwards. The Office of Provider Standards and Certification, Office of Program Operations, and finally, an Office of Program Appraisal and Data Planning.

This office doesn't contain the necessary staff yet. We will be moving a small group from one of the HSMHA components from the medical care standards group into it, but it does not yet contain the level of staffing that we anticipate. As you know, we have a major set of initiatives in health care, a number of items very high on the priority list at this time.

BUREAU OF QUALITY ASSURANCE



Dr. EDWARDS. Mr. Chairman, it is important to recognize one of the most important things we are doing is the development of this Bureau. This Bureau is, if we move to a national health insurance scheme of some kind, and if the health establishment of the Federal Government is going to have some input into the quality of health care that is being rendered in hospitals and by physicians, we have got to have some focal point where these standards, criteria, guidelines, what have you, are being developed and in our judgment this is the beginning of such an effort. This is the beginning of a group that is going to work to try to get more health input into the health issues that arise each day.

We have three units that are involved in PSRO activities, one in the VHIF, the Social Security Administration; one handling medicaid, and one in this particular Bureau. Dr. Bauer directs these activities. We have established for Dr. Bauer an operating committee of which he is chairman. The head of the Bureau of Health Standards, and the Bureau of Medical Services or BMS, are also members of this operating committee. So we think we have given Dr. Bauer the overall position that he needs to run the PSRO program.

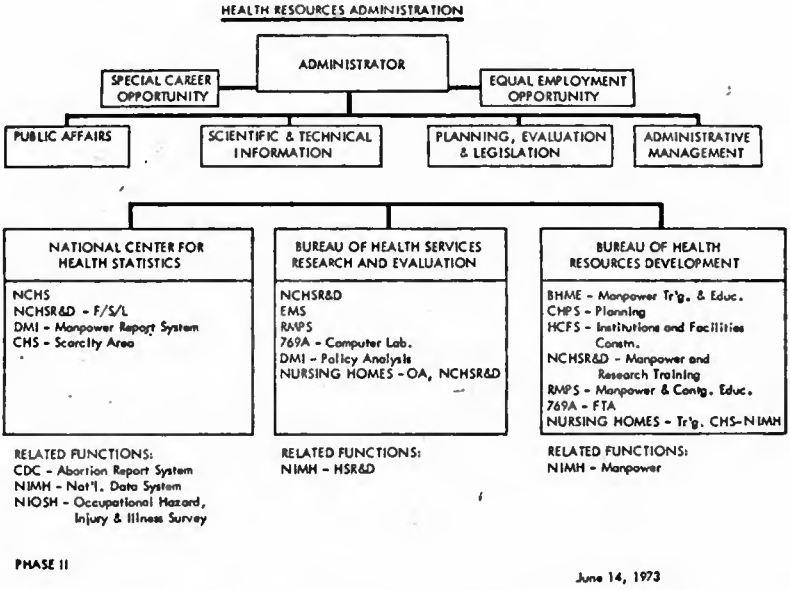
Mr. ROGERS. Thank you.

Dr. EDWARDS. Mr. Chairman, I would like now to have Bob Laur run very quickly through the Health Resources Administration which is the second unit. As you know, the other unit is the CDC which will be an independent agency under our reorganization. It does, after all, represent the preventive medicine aim of the HEW, and we felt that it deserved independent status in that role.

Mr. LAUR. Thank you, Mr. Chairman.

The Health Resources Administration is an attempt to group some activities that are already in existence in the prior Health Services and Mental Health Administration in a way in which community-level providers of health services, the Congress, the Department, and Dr. Edwards' office, all will find, I think, a more useful arrangement.

This is a big order, to satisfy so many different groups. We have tried to eliminate what we felt were some problems in those programs that were in HSMHA which were trying to foster innovation and new approaches to the delivery of health services.



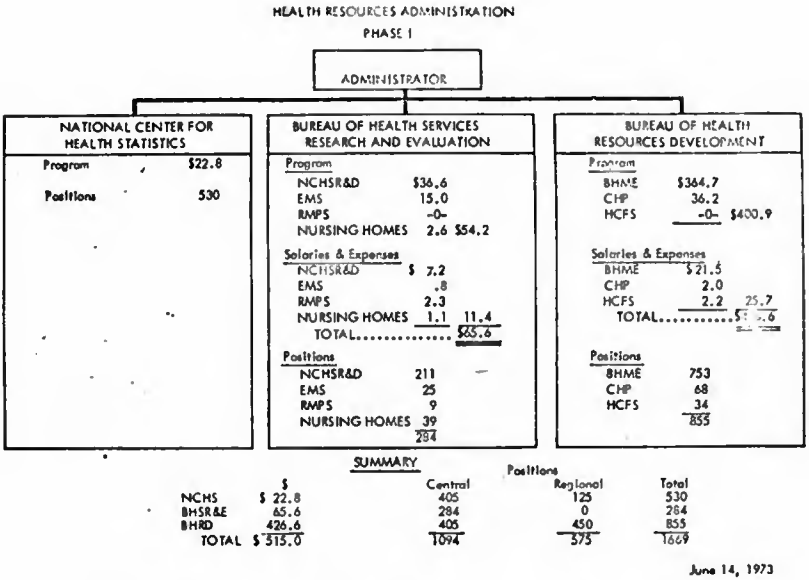
Mr. LAUR. The Resources Administration as is now created consists of three major operating components, Mr. Chairman. One is the National Center for Health Statistics. A second is the Bureau of Health Services Research and Evaluation and third, the Bureau of Health Resources Development.

There are a couple of administrative level boxes on the chart I would like to briefly touch on. One, labeled "Scientific and Technical Information." we are not really sure what that should be called, or how it should be described, but we are very certain of one thing, in that there has been an inadequate ability on the part of the organizations that make up this organization to communicate with Congress, with people concerned with health policies, and with people trying to improve the delivery of health care.

For example, we must find ways in which advances in the delivery of health care which are discovered or which become available in one part of the country can be more rapidly disseminated.

Equally, we need to find ways in which the problems which exist in communities and States in the delivery of health care can be brought to the attention of those people responsible for Federal resources aimed at solving those problems.

In short, we are hoping by some device—and it may not turn out to be an office at all; it may turn out to be other kinds of activities—to find ways to more readily and quickly understand what the problems of the country are and to communicate whatever knowledge, understanding, or technical assistance or other resources the Federal Government has been able to develop which are aimed at improving the delivery of care.



Mr. LAUR. Now this chart, Mr. Chairman, shows what we call phase 1 of the Health Resources Administration. It simply reflects the grouping of those programs which were moved into it when the Administration was created, specifically the National Center for Health Statistics, the Bureau of Health Services Research and Evaluation, and the Bureau of Health Resources Development. The National Center for Health Services Research and Development existed before under the Health Services and Mental Health Administration. Added to it are the Emergency Medical Service Activities and the Regional Medical Program.

In the Bureau of Health Resources Development are found the Bureau of Health Manpower Education, which formerly was located in the National Institutes of Health, the Comprehensive Health Planning Service and the Health Care Facility Service, the Hill-Burton program.

Without taking you through all the details, unless you would, of course, like me to, these three Bureaus comprise the following kinds of resources. About 1,700 people are employed in them. The total financial resources represent $51.5 million, and some of the agencies activities will be carried out in the regional offices, utilizing some 600 planned regional office positions.

Mr. ROGERS. Now what will they do in these regional offices? What decisions would be made there?

Mr. LAUR. Some of the grant programs are in fact decentralized to the regional offices for decisionmaking there.

Equally, on some of the formula programs a monitoring of State plans and State activities is conducted by regional offices and in some instances the regional offices serve as the principal point for the provision of technical assistance to communities wishing to improve their health manpower activities.

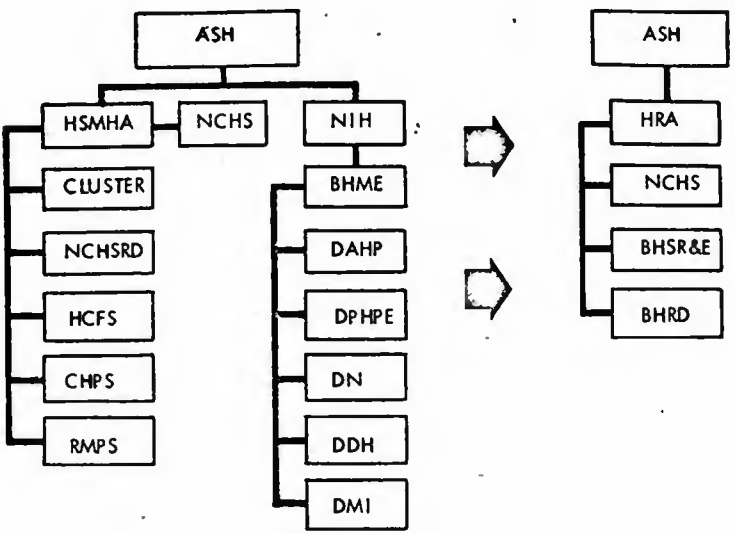
Just very briefly, Mr. Chairman, I can show you what we think, in an administrative sense, the reorganization has provided in the Health Resources Administration.

Having worked in HSMHA for some time myself, I think I could express the view that the people working here are rather rare resources, precious resources. There aren't very many people who can help think through community and State and National problems associated with the delivery of health care.

The deeply felt testimony the committee has heard this morning expresses the numerous values and approaches that have to be accommodated when one tries to move the delivery of care, and there aren't too many people we have available to help think through those issues.

In the former HSMHA administration, all of these various organizational units were involved in the provision of that kind of national leadership, not only within HSMHA and the National Center for Health Statistics but—all of whom reported to the Assistant Secretary for Health.

HEALTH RESOURCES ADMINISTRATION



2 AGENCIES

HSMHA - ADMINISTRATOR
DEPUTY
DEPUTY (CLUSTER)
5 - PROGRAM DIRECTORS

NIH - ADMINISTRATOR
DEPUTY
BUREAU DIRECTOR
5 - DIVISION DIRECTORS

1 AGENCY

HRA - ADMINISTRATOR
DEPUTY
3 - BUREAU DIRECTORS

June 14, 1973

Mr. LAUR. So we had two major Federal agencies and five different program directors and numerous division directors all involved in that attempt to use the scarce resources well.

Under the reorganization, as you can see, we are now dealing with simply one agency and three major bureaus. We think that will provide a way to use scarce resources not only more intelligently but perhaps more expediently.

Mr. ROGERS. Well now, do you still have the same people involved? Did you simply group them in less numbers of boxes?

Mr. LAUR. That is correct. The same people at the moment are simply working in HRA.

Maybe this would be the appropriate time to spend just a moment on what we think might emerge in HRA.

It doesn't change, of course, in the major components. Those three major bureaus stay the same, but as an example the National Center for Health Statistics is not a very exciting activity in the sense that dramatic health care is not rendered there. Lives are not immediately saved, but in terms of the concerns of this committee and many people working in the country to help improve care, it is very clear that we need a better information base from which to proceed.

The discussion this morning about morbidity and mortality are but the surface of a much larger problem that has to do with how well do our various approaches to infant mortality really work, which systems produce the best results and under what conditions.

So we are hoping that the National Center for Health Statistics will indeed become a national center, not just for vital statistics, births and deaths, but for the operation of the Nation's health system. What the status is of America's health is what we hope that system can assess. So we intend the functions of this Center to be some of the other key statistical and information processes now scattered throughout HEW. For example, the cooperative Federal, State, local statistics system, a really exciting departure to minimize the number of duplicating statistical systems around the country, the health manpower statistical series formerly carried out at NIH, and many other statistical services that we can envision there.

Similarly, in the Bureau of Health Services Research and Evaluation there needs to be a focusing of the research activity of the country so we propose to add some additional functions, grouping them there, with the same people, Mr. Chairman, but we believe more carefully coordinated.

Mr. ROGERS. May I interrupt now? I am sorry.

There is a meeting of the full committee to begin at a quarter of 12. I think the members of the subcommittee will be required to attend that.

If it would be convenient for you, Mr. Secretary, and for your associates—and I am sorry to interrupt you in the middle of your presentation—could we meet again at 2 o'clock this afternoon so we could complete the testimony of HEW today, so that we can continue on schedule with our other witnesses tomorrow. Will that be convenient for the members?

Mr. CARTER. Mr. Chairman, I would like to be here at that time, but as a partner in the Esch-Carter amendment to reduce the military budget and our troop commitment in Europe, reduce the budget by over $1 billion and do the very thing that some of the people have

talked about here, I am afraid I won't be able to be here. I will be on the floor of the House, but I trust that the people who have spoken so much about the bombing and so forth will be there to assist me in reducing this appropriation so we can use it in health.

Thank you, Mr. Chairman.

Mr. ROGERS. That sounds good.

Mr. CARTER. You have read the amendment, I trust?

Mr. ROGERS. Yes, I have. I know you will present it well.

Under those conditions, the committee will stand adjourned until 2 o'clock this afternoon.

[Whereupon, at 11:50 a.m., the subcommittee recessed, to reconvene at 2 p.m., the same day.]

AFTER RECESS

[The subcommittee reconvened at 2:30 p.m., Hon. Paul G. Rogers, chairman, presiding.]

Mr. ROGERS. The subcommittee will come to order.

We will continue our hearings on the oversight of the proposed reorganization of HEW. We were in the middle of a presentation by Dr. Laur when we recessed this morning.

I am sorry to have interrupted you Mr. Laur.

Mr. LAUR. I believe we really completed the major part of the presentation, Mr. Chairman. You will recall that the Health Resources Administration consists of three major bureaus: National Center for Health Statistics, Bureau of Health Services Research and Evaluation, and Bureau of Health Resources Development.

Mr. ROGERS. What are the health services that you are concerned with?

Mr. LAUR. This is an attempt within the limits of semantics, Mr. Chairman, to distinquish between the research that one would find at the National Institutes of Health basic medical research and biomedical research. It deals with the appropriation of health services, how they are organized, financed and arranged and made available to people who are sick or who are trying to avoid becoming ill.

Mr. ROGERS. But it is only research?

Mr. LAUR. This particular Bureau, we have called the Bureau of Health Services Research and Evaluation so it embraces that spectrum of activities. Perhaps it should be more appropriately labeled applied research. It is not fundamental social science research.

It tries to discover solutions to problems that have emerged for which a solution is not readily apparent. It is the mission of that Bureau to try and see that that discovery is made widely available in America to whoever can take advantage of it and it is their mission to test whether or not what we thought was a good idea is, in fact, working. So it covers that gamut form research to testing.

Mr. ROGERS. Where the Community Mental Health Service program has been continued, where would that evaluation fall?

Mr. LAUR. The Community Mental Health Center's activity is still within NIH.

Dr. EDWARDS. But that would not be that mental health being part of the overall health establishment—perhaps not as much as some of us would like to see it—but nevertheless some of the things should be evaluated and could very well be evaluated by this organization.

Mr. ROGERS. But the actual administration of it would be where?

Dr. EDWARDS. Oh, in the National Institute of Mental Health.

Mr. ROGERS. All right.

Mr. LAUR. I believe, Mr. Chairman, we do have a couple of charts that display some of the advantages we think we have obtained with this.

Mr. ROGERS. I think there will be a couple more members here in just a minute. Would it be well to cover anything else?

Dr. EDWARDS. I think it might be well for the chairman to see these two charts.

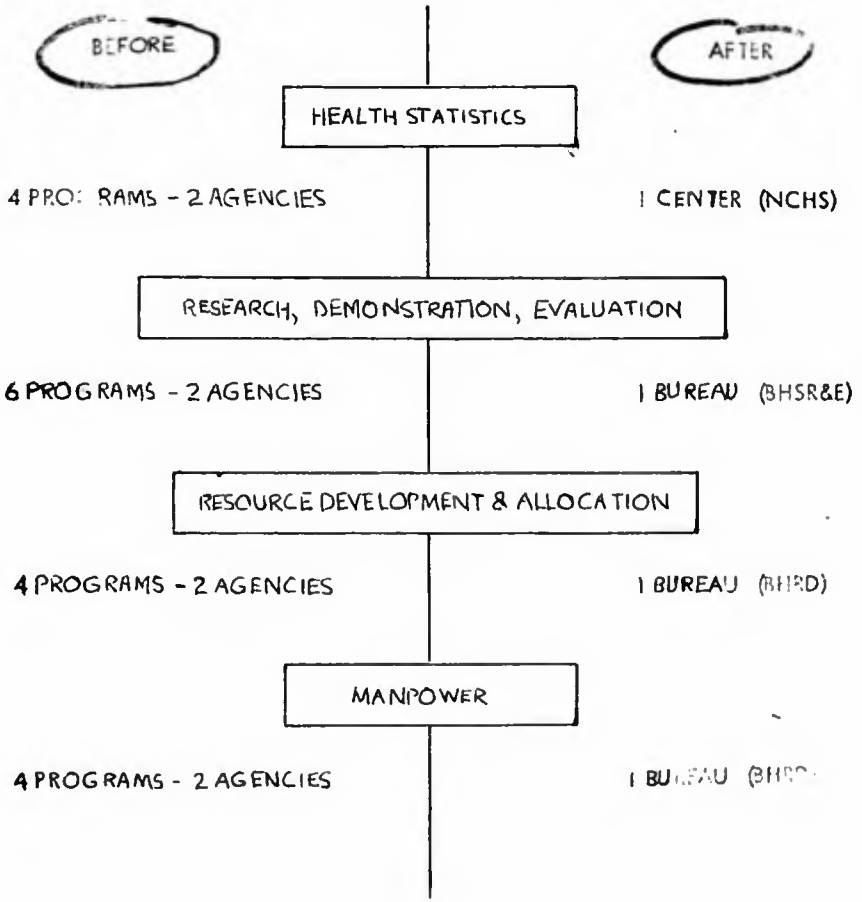
HEALTH RESOURCES ADMINISTRATION

STRENGTHENS

Decisionmaking processes.
Program coordination and dissemination of policy, data, and research findings—to regions for implementation.
Federal role in health statistics, planning, and research.
Resource development by joining manpower, facilities, and health planning.

HEALTH RESOURCES ADMINISTRATION

PROGRAM FUNCTION ADVANTAGES



Mr. LAUR. These speak principally, Mr. Chairman, to administrative and managerial advantages because this was essentially an administrative and managerial attempt to improve things. There are four major functional areas that engage the attention of the people who work in the Health Resources Administration.

I spoke earlier to the attempt to develop a more effective National Health Statistics program. There is the research demonstration and evaluation function that we have just described. There is the function of developing health resources, manpower, organizational arrangements and physical facilities and seeing that those resources are better allocated throughout America. That function and the manpower function being so critical, I have left as a separate item here.

In the prior structure of HSMHA before the reorganization, each of these functions involved from four to six different programs within two Agencies, HSMHA and NIH. You can see in each case now they are all within one agency, the Health Resources Administration and each of them is encapsulated within one of the major operating components, one of the bureaus, so we think just in the sheer mechanical arrangements of budget preparation and evaluation, internal management, we have simplified a great deal and made it possible to be more effective.

This is simply another way of saying some of what I have said here. The reorganization, we think, does streamline the decisionmaking process around these resource development activities and provides for better coordination of them, and I would like to speak for just a moment here to a concern which I know the committee has and that is decentralization.

There are many ways to accomplish decentralization besides simply moving a program into a regional office. Even when one decides to give major decisionmaking authority to the regional offices for grants, as some of our programs are, there is a counter or a complementary necessity to strengthen the policy direction that originates in Washington so that those regional offices clearly understand what it is they are to be carrying out under that decentralization authority.

We think this reorganization has made it much more possible for the components of HRA to do just that, to give clearer direction to the regional offices in those programs that are decentralized. That has an advantage, I think, way beyond the regional offices, which is, if we can make it clear to the regional offices what we are, perhaps the public and physicians and hospitals and health departments can also understand more clearly what the program really intends and what it does not.

We think that will simply be a crisper portrayal of what the policies and guidelines are. And finally, in reiteration, by bringing together the developmental programs in the Government for health manpower, the most important of all health resources, for facilities, and for organizational planning, we think one can begin to develop a more related systematic approach.

I think, Mr. Chairman, that concludes the chart presentation.

Dr. EWARDS. Mr. Chairman, in our judgment, this Health Resources Administration, for the first time puts, into a manegeable unit those Federal resources that are necessary to develop any Federal—I am not just talking about the executive branch, but for you and the Congress as well.

In other words the collecting of health statistics and the analysis thereof have some meaningful impact on the development of a health policy or strategy. I think the proof of the pudding is in the eating and whether we can pull it off, I don't know for sure, but I think first, we have the organization that will give us that kind of capability.

Mr. ROGERS. Mr. Nelsen.

Mr. NELSEN. I don't know that I have any specific questions but I want to refer to the hearing the other day in which we learned that we have about 400 commissions or committees set up by various agents of Congress with per diem and travel expense and the overlapping of these various commissions is quite extensive. It would seem to me that if we are going to make revenue-sharing work, if we are going to get the best utilization of manpower, a reorganization in any agency of Government is certainly a step in the right direction.

But I realize it is never easy to make those changes and I want to compliment those of you who are attempting to effect such a job in reviewing it with us and then hopefully to accomplish the goal that you set out to do.

Mr. Chairman, I told you I would be here this morning for the meeting and we were detained in an airport in Minneapolis for an hour and one-half, mechanical trouble with the plane, but I understand I missed a pretty good political show. I hope that I can get a copy of the transcript of this morning because I may want equal time on a rebuttal and I can assure you I won't hesitate to do it. Thank you.

Mr. ROGERS. You certainly may have a copy of the transcript and you certainly are entitled to a rebuttal and I may be entitled to a rebuttal myself because I din't say anything this morning either, but I may.

Mr. NELSEN. Fair enough. I will accept the challenge.

Mr. ROGERS. It is given.

Mr. Roy.

Mr. ROY. Thank you, Mr. Chairman.

Reviewing the organizational structure and the objectives that you wish to achieve, it has been stated that the new organization must provide for the phaseout of major health service activities. What activities are you talking about?

Dr. EDWARDS. Would you say that again?

Mr. ROY. The new organization must provide for the phaseout of major health service activities.

Dr. EDWARDS. No, it doesn't do that. I think that again it is public information. We didn't try to hide it. We in essence said to the committee under Mr. Smith's direction and this management group that we pulled together that one of the charges is that they couldn't do this study in isolation. They had to recognize what the implications were of the President's budget.

The fact of the matter is we haven't phased anything out. As a matter of fact, I would say without any fear of contradiction that this management plan or this organizational plan that we have here is just as appropriate with or without RMP's with or without Hill-Burton, or what have you.

Certainly it wasn't our intention to have an organizational plan that represented any kind of a phaseout.

Mr. ROY. I think, Mr. Chairman, I will yield to you for any questions you may have and with your permission, I would like to reserve a little time thereafter. I know we have some similar questions.

Mr. ROGERS. Mr. Hastings?

Mr. HASTINGS. Mr. Secretary, there have been allegations made, spoken I guess more than written, that, in fact, the reason for the reorganization is only to get rid of those programs that you have not been able to fund. I will make it perfectly clear that I was not and am not an originator or supporter of those statements, but since they have been made, I would like the reaction, precisely the argument that you have in opposition to those views.

Dr. EDWARDS. I have a very real opposition to it. I think that any of us, you on this committee, others who have watched Government over the last 4, 5, 6 years, we won't have to be convinced that the former Health Services and Mental Health Administration was not accomplishing what it was supposed to accomplish.

I have had in my position as head of FDA, an opportunity to look at it at a little distance, but yet fairly close enough that I could see some of the problems. So when I came on board, I went to Mr. Carlucci and Secretary Weinberger and said, "It won't work. We have got an organizational structure that even Dr. Wilson had indicated was not a viable organizational structure."

This came completely at my initiative. It had absolutely nothing to do with the phasing out of programs or anything else. It was purely an organizational management decision on my part and supported by the Secretary.

Mr. HASTINGS. What is the time frame of the decision that set this in motion?

Dr. EDWARDS. I can't give you the exact dates; but it was in December when I first talked to Mr. Weinberger about my current position. I brought this particular issue up and made it a formal proposal. Shortly after, I went over on a part-time basis in January and he, at that time, gave me the go-ahead and I think it was in February that we asked Mr. Smith to put together a team with appropriate representation.

How large was the team—six people from the various agencies, and it was over the next 2 months that they put together and we presented to the Secretary the initial skeleton of our proposed reorganization.

Mr. HASTINGS. Without serious objection from the Congress, when will this reorganization go into effect?

Dr. EDWARDS. The first phases of it went into effect on July 1. I had personally talked to a few people including the Chairman, about it. By the time this becomes a fait accompli, in other words, you were talking about 27,000 to 30,000 people. We are talking about a budget of $2 billion. A reorganization like this, as you well know, is a very complex, complicated undertaking.

Job descriptions have to be written for all of the key people in this organization, and so forth. So the initial laying out or the initial discussion of the general layout has already been accomplished. We are now beginning to work and will continue over the next few months. It will probably be the first of the year before all of these things are put into place.

Mr. HASTINGS. I have no further questions. Just one comment. It seems to me that so often when this subcommittee sits down to write legislation, we talk about reorganization, moving an agency in or out of where they presently are, for the reasons it has not effectively worked as the legislation put in place intended it to work, so I would hope that the subcommittee would not just take any overall opposition to any reorganization without looking very, very carefully into the intent and that is hopefully delivering health care.

Mr. ROY. Mr. Chairman, may I ask one question at this point?

Mr. ROGERS. Yes.

Mr. ROY. Your reply to Mr. Hastings' statement is a little bit different than what I would read into a February 20 memo which goes to Mr. Smith from you, Dr. Edwards, stating, "The administration has made a number of policy decisions on direction of Federal programs for health services which will have a major impact on health services and mental health administration and its organizational structure.

"Accordingly, Secretary Weinberger has asked my office to undertake a broad review of HSMHA's programs and organization and their interrelationships with the other health agencies. We are to submit to him, within a period of 2 months, an organizational plan which will, first, reflect recent and projected changes in the programs administered by HSMHA, and, second, be designed to help achieve the Department's goals in the field of health services with maximum management effectiveness and efficiency."

I don't know whether you see any conflict in that in your answer, but at least this says Secretary Weinberger requested you to reorganize the Department.

Dr. EDWARDS. He requested me at my request.

Mr. ROY. And No. 2, it says these are to reflect recent and projected changes in the programs administered by HSMHA, and what I have been objecting to, and I think others in the Congress have been objecting to, is the fact that these decisions appear to have been made unilaterally by the administration and this is indeed a de facto going forward without legislative direction.

Dr. EDWARDS. No, not at all.

As I stated earlier, in putting together this organizational framework, we had to be sure that they were organized in a way so if the administration's budget did go through the dropping of a program, it wouldn't, for all practical purposes, destroy the continuity of a particular bureau or agency.

As I say, I feel, without any reservations, that this organizational plan was structured to handle the programs that we currently have and that is no phase out. I think the current organizational structure would also be as effective if we did phase some of these programs out, but it certainly was not put together with the idea in mind that these programs would with certainty be phased out.

Mr. ROY. Mr. Chairman, I would like to ask unanimous consent to put this memo in the record, if I may. I still read it somewhat differently than your response to Mr. Hastings' question. The No. 1 purpose being to reflect recent and projected changes in the programs administered.

Dr. EDWARDS. I can give you the background of the issue, Congressman, and I think Secretary Weinberger would confirm that this was

instigated solely by me and that memo, regardless of how you interpret it, was intended to suggest or request me to move ahead with my plan to develop the reorganization, but in the process not to lose sight of the fact that the administration was proposing some significant budget changes, program changes.

Mr. ROY. Thank you, Mr. Chairman.

Mr. ROGERS. Without objection, it may be made a part of the record.

[The document referred to follows:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
February 20, 1973.

To: Mr. David Smith, FDA.
From: Charles C. Edwards, M.D.
Subject: Review of HSMHA's Program and Organization.

The Administration has made a number of policy decisions on the direction of Federal programs for health services which will have a major impact on the Health Services and Mental Health Administration and its organizational structure. Accordingly, Secretary Weinberger has asked my office to undertake a broad review of HSMHA's programs and organization and their interrelationships with the other health agencies. We are to submit to him, within a period of two months, an organizational plan which will (1) reflect recent and projected changes in the programs administered by HSMHA, and (2) be designed to help achieve the Department's goals in the field of health services with maximum management effectiveness and efficiency.

I am asking you to be project leader for this review. You will have the assistance of full-time staff drawn from the health agencies, my office, and the Office of the Secretary. Maximum effort should be made to achieve as broad participation as possible by the major program operators through interviews.

The target date for completion of the review is April 15. Your assistance and that of your colleagues on this important undertaking is very much appreciated.

Mr. ROGERS. I have gone over this report entitled, "Review of Programs and the Organization of Health Services and Mental Health Administration," which is prepared for the Assistant Secretary of Health and dated April 5, 1973. Without objection the report will be printed in full as an appendix to this hearing. [See p. 203.]

I am just concerned about some of the statements in here. I don't know the full significance. For instance, NIMH is divested of its responsibilities to finance the operation of community mental health centers and other mental health training and services begin to assume the characteristics of NIH.

Then major health program will be terminated by the end of fiscal year 1974. Support for mental health centers, alcohol abuse centers, long-term training will be gradually phased out beginning in fiscal year 1974. Project grant support for maternal and child health service will be replaced by formula grant funding.

The Bureau of Health Manpower and Education budget calls for the termination of categorical support in allied and public health and for schools of nursing, veterinary medicine and so forth. I would hope that these are assurances you are giving me and the committee that the reorganization is not really to carry out what is stated in that report, which, in effect, would negate the action that Congress has taken and that the President has approved in these particular categories.

Dr. EDWARDS. I can give you complete assurance, Mr. Chairman, that it isn't. However, if you would so desire, I would have Mr. Smith, who headed the study, speak to this point. He is responsible for writing the report.

Mr. Smith, do you want to speak?

Mr. ROGERS. Mr. Smith, identify yourself for the record, please.

Mr. SMITH. I am David Smith, Food and Drug Administration.

You must keep in mind now the chronology of when the study was undertaken. The memo that Dr. Roy has read was dated, I believe, February 20. This was, in fact, even prior to Dr. Edwards' appointment confirmation in his present position. The President's budget had been delivered.

Hearings were just beginning to take place. It was, I think, common public knowledge, reported certainly in the Wall Street Journal and New York Times, the popular press, and other publications, that certain programs were, in fact, planned for phaseout.

In writing a report such as this, we felt it was critical to establish the basis that the analyses were performed, the situation at the time we conducted our analyses. You will also note that the report was delivered—I believe the date on that document is the 5th of April, which was prior to any subsequent congressional action on the Health Services program, so at the time the study was conducted this was the apparent direction of not only programs in the Health Services and Mental Health Administration, but the National Institute of Health as well.

So it was on the basis of the situation at the time that these, in fact, were, at least according to our study group, statements that certainly the reorganization must take cognizance of if these programs were going to be terminated as proposed in the President's budget.

Certainly a reorganization must provide for that. But again, as Dr. Edwards says, the reorganization is just as valid even though this program is continued.

Mr. HASTINGS. Mr. Chairman, could I ask a question?

Mr. ROGERS. Surely.

Mr. HASTINGS. Will you tell me is this reorganization plan then flexible enough to accommodate any changes that this Congress does, in fact, make?

Mr. SMITH. Yes, sir. I think it definitely is flexible. Although a functional alinement in terms of managing different aspects of the program is assumed, it does not in any way do away with categorical programs, but hopefully eliminates some of the duplication that we saw in functional areas from program to program to program.

Dr. EDWARDS. I think this reorganization takes exactly that particular issue into account. One of the problems when you assume just a categorical approach, a program suffers from the whims of the Congress and the executive branch and so forth in terms of its ups an downs, with respect to the funding and resource allocation.

At least to a degree, going the functional line, we keep a certain resource stability that you don't have with merely a categorical approach to each and every program. Where each and every program has its own separate resources, they never communicate with each other.

If a program then suffers some of the problems that can happen to programs, and you know some of them, then major problems ensue. I think this kind of an organizational arrangement gives us a stability that we didn't have before.

Mr. HASTINGS. On a couple of specifics, for example, take migrant health or CHP, where they might wind up in this reorganization suggested here doesn't necessarily increase or decrease them in importance as they are today.

Dr. EDWARDS. Absolutely not. We have very high visibility for all of them.

The identity, in order to get a response to program inquiries is there. The functional approach comes at a level below that, and even under that arrangement, there will be categorical kinds of organization within the functional categories. But, at least it will give certain management flexibility that does not exist under the strictly categorical approach.

I don't think I, as the head of the health establishment, should tell my managers exactly how they ought to be utilizing their resources. I can tell them what their responsibilities are, but I have to allow them some flexibility in terms of how they utilize and carry out these responsibilities, and I think that that same principal in a sense applies to Congress.

I think if we don't do the job, then you get rid of the Assistant Secretary for Health and a few others; but again, we can't get down to the nitty-gritty of the day-to-day operations of these units. That is my management philosophy.

Mr. ROGERS. Mr. Smith, may I ask you, did your panel go over the laws? Did you consider the intent of the Congress and the laws of the land when you proposed the reorganization?

Mr. SMITH. Yes. Mr. Chairman, we did. In fact, the General Counsel of the Department reviewed the recommendations with regard to the intent of the Congress as well as the statement of the enabling legislation.

Mr. ROGERS. Did you consult with any members of staff of the Congress?

Mr. SMITH. No, sir.

Mr. ROGERS. Did you consult with any affected groups.

Mr. SMITH. No, sir.

Mr. ROGERS. It was just strictly within——

Mr. SMITH. In the Department.

Mr. ROGERS. In the Department?

Dr. EDWARDS. I think in retrospect, Mr. Chairman—not that I think it would have changed our opinion particularly—but I think we should have gone on record as having consulted other groups. As you remember, it was totally informal, I consulted with you on several occasions in a very general way, not that you had any presentations like this, but we talked general principals.

I talked general principals with a number of people, and God forbid for any other reorganizations that I ever get involved in—you know you learn by living—I would have a little bit more direct input.

Mr. ROGERS. There would be, as I understand it, 960 people working in the office of the Assistant Secretary. Is that correct?

Dr. EDWARDS. That is approximately correct.

Mr. ROGERS. How does this compare with prior activity and prior manpower?

Dr. EDWARDS. It is considerably more, Mr. Chairman, but I think that is also indicative of why the office of the Assistant Secretary for Health has never been very effective. It is one thing for a Secretary or President to say you have line responsibility over certain organizations. It is another thing to carry out that line responsibility.

For instance, it is totally impossible for the Assistant Secretary to play a significant role in the development of the budget each year without a budget staff of his own that can look at the agency's budget in a more or less objective frame of mind.

I know when I was the Commissioner of the Food and Drug Administration, I can assure you that I did not objectively look at the HEW budget. I was interested in FDA's budget. I think that in view of the fact that we are likely to be living, at least for the foreseeable future, during times when budgets are going to have some restrictions placed on them, it is absolutely essential that there be an Assistant Secretary for Health or a Health Administrator, whatever you want to call him, who does coordinate budget, personnel, and the overall health policy development.

Mr. ROGERS. So you will have your own budget capability, then, and all of the constituent agencies must clear their budgets through you rather than through the Comptroller of the Department?

Dr. EDWARDS. And we will be dealing directly with the Comptroller.

Mr. ROGERS. As a lump budget rather than constituent parties?

Dr. EDWARDS. We will have to break our budget down to the Comptroller. If I may say so, I think that, for instance, recognizing the parameters of the President's 1974 proposed budget, that while the total amounts wouldn't have changed, I think that if there had been a strong "H" input, some of the allocations might have been different.

Mr. ROGERS. I agree with you. I think you need a budget control because they have turned it over to the Comptroller of the Department, and he put the need of other constituencies in the Department above health.

Dr. EDWARDS. I would certainly want to emphasize for the record too that in my judgment, Mr. Cardwell is probably one of the more able comptrollers in the Federal Government and I don't mean in any way to cast any aspersions on his capabilities, but I just think that——

Mr. ROGERS. You need——

Dr. EDWARDS. You have got to have somebody look at the total health budget as a whole and not in its individual pieces.

Mr. ROGERS. Yes, I think that is true.

Now, how does this build-up of the Assistant Secretary's office square with decentralization?

Dr. EDWARDS. Well, again, we haven't decided exactly how we are going to decentralize and even to what degree. First of all, it changes the reporting relationship of the Regional Health Administrators. They used to report to the Director of HSMHA and now they report to the Assistant Secretary for Health and we have established in my office, not unlike what we did at FDA, a key person in my office who coordinates what is going on here in Washington in the health policy area with what is going on in the field under my direct supervision.

So I think, in other words, we are looking at the role of the regions in light of the total health effort and not just as it relates to one agency.

Mr. ROGERS. I hope national programs will not be so splintered through regionalization that it will be difficult for us to know what is going on and proper decisions to be made.

Dr. EDWARDS. I don't think, Mr. Chairman, there is going to be that splintering. I think there are certain logical responsibilities that can be—this doesn't mean by any stretch of the imagination, that

total program responsibility is going to be pushed out to the region but, on the other hand, there are certain contract grant monitoring functions, and so forth, that can probably be done better in the region, if we can get the staff, than by a group here in Washington. But in no way are we delegating that policymaking, per se, nor are we suggesting that we are going to give up the overall direction in these programs to each and every one of the 10 regional offices. It just isn't going to happen.

Mr. ROGERS. How will your office relate to medicare and medicaid?

Dr. EDWARDS. That is in the process, of course, of being—the exact way is still not up for grabs but it is being looked at very seriously. I think everybody recognizes that heretofore the Assistant Secretary for Health has not had as much of an input into the health issues that go into medicare and medicaid as perhaps should be the case. One of the reasons he hasn't, very frankly there are a number of reasons, is that he hasn't had his own capability of getting his input. I think the Secretary is completely convinced that this has to come about prior to the time we get a national health insurance where we are not going to have medicare and medicaid but a total blanket financing plan. We are setting up in our office right now a major position directly under me in which this particular individual is going to have control over policy development, evaluation, and also the relationships or interactions with SSA, MSA, and SRS. As you know, the committee that looked at the HSMHA operation and developed the reorganizations plans recommended that BHI and MSA be transferred to "H." My own personal knowledge was that maybe that might have to happen at some time but there should be something short of a direct physical transfer of these people. In other words, I still think there is nobody who writes checks quite like the SSA writes checks and I think we are hopeful that this can be done by a more aggressive and formalized way of getting our input into the equation.

Mr. ROGERS. In other words, that will allow you some program and policy decisions, although the money could be raised and expended the same way?

Dr. EDWARDS. That is right.

Mr. ROGERS. And also I presume where regulations would be issued, you would have approval of those concerning program and activity.

Dr. EDWARDS. That is exactly correct. No SSA program regulations that involve health can be promulgated until they were approved by and had the input—and I think this is improving. Right now the regulations that are the interim and the long-term regulations on the regional dialysis programs, "H" has had the lead responsibility in the development of these.

Mr. ROGERS. Well, I think most of the members on this committee feel very strongly that you as the chief health officer should have a major say-so in these decisions, and certainly in promulgating resolutions having to do with medicare and medicaid.

Dr. EDWARDS. I feel strongly about that, likewise.

Mr. ROGERS. It is encouraging that such an attitude is developing.

Now, what will your role be in developing the national health insurance plan that the administration says they will submit? Are you having a major input into that?

Dr. EDWARDS. Yes. Of course, the organizational responsibility for this has been given to the planning people prior to my joining the

establishment and they still have the responsibility for formulating the final plan. I think that under normal circumstances we should probably have been given that responsibility, but I think things being as they were at the time, it was appropriate that this responsibility was given to them. Since then, however, we have played a very important role and one of the key recommendations the Secretary is considering is a recommendation that was developed by the health group at HEW.

So when I think that some of the responsibilities that I would normally consider as the health group's responsibility at HEW probably have been assumed more via the legislation route. The Assistant Secretary for Health didn't have the capabilities in his office to do some of these things.

Mr. ROGERS. Now, in some of these charts it seems the same subject is covered in places like in the Office of the Assistant Secretary as well as in the agencies. For example, are functions concerning PSRO, nursing homes, family planning, and population duplicated at the various levels? How do they operate and why is it necessary to duplicate them?

Dr. EDWARDS. Most of these, particularly in PSRO and family planning, were mandated by the Congress. It was made very clear in PSRO that the direction of the PSRO program should come from the Secretary and be delegated to the Assistant Secretary for Health. This we have done. I think if Dr. Bauer and our office are as successful as I hope we are in the development of this program, that 2 or 3 years from today, or 4 years from today, our success will be measured by the fact that we can do away with it and push it down to the Bureau where it probably should have been at the beginning. At this time it is being managed and directed by Dr. Bauer, but again that is because Congress wanted it that way, not that I would have put it that way from a management point of view. I might have, but it wasn't our idea necessarily. This is also true with family planning. I believe I am correct in that the Congress mandated a position of Deputy Assistant Secretary of Health for Family Planning, namely, in the person of Dr. Hellman, who coordinates the family planning activities of the various organizations in NIH and now the Health Services Administration.

The nursing home function was established by Secretary Richardson in an effort to try to get some coordination with SSA and SRS in terms of nursing home regulations.

Mr. ROGERS. But if you have it in your office, although it is true that Congress thought it should be placed there, why should it be duplicated by an agency down below?

Dr. EDWARDS. Mainly because I see our office, particularly in nursing homes and family planning functions, merely as a coordinating unit, not in developing programs or anything else, but being sure in a coordinating role that the agencies involved were working together and that the appropriate groups were having an appropriate input into the final product.

Mr. ROGERS. What about health manpower strategy that you talked about last week? Would that be written by your Office of Planning or the Health Resources Administration?

Dr. EDWARDS. It would have an input—it should have an input, a very major input from several areas. It should have a major input

in the health manpower group and their intelligence gathering unit. We need a major input from NIH. We probably need a major input from the CDC. I think there are a number of people that have to have some input into a manpower strategy.

Mr. ROGERS. Is this being done now?

Dr. EDWARDS. All of this information has either been gathered or is in the final phases of being gathered, and I would hope—I won't go so far as to say we have the final answer in terms of a long-range strategy, but we will have some very specific recommendations to make to you and this committee in the early fall, at least as an interim position.

Mr. ROGERS. How does your office relate to the Assistant Secretary for Planning and the Assistant Secretary for Legislation? There are two offices in the Department, one for planning and one for legislation. How does your office, which has comparable rank, relate to those?

Dr. EDWARDS. As a matter of fact, our office has a different kind of rank. We are an office with line responsibility. They are staffed through the Secretary. For instance, the Office of Planning and Evaluation ideally, has a responsibility to evaluate for the Secretary any major plans that we in the health establishment submit to the Secretary for his approval. They have a responsibility to evaluate our planning efforts in the health establishment, in our supervision of the agency's planning efforts. So they do have a big role and it is a very important role.

In the field of legislation, we obviously have to have some day-to-day capabilities in the legislative field, but Mr. Kurzman, for the Secretary, has to coordinate all the Department's legislative efforts and of course, we have a very close working relationship with Dr. Zapp, and I suspect he is as much a member of our staff as he is a member of Mr. Kurzman's. I don't know if Mr. Kurzman would agree with me on that.

Mr. ROGERS. Well, do you have your own legislative capability in your office, or are you developing it?

Dr. EDWARDS. We are developing a group that works with Dr. Zapp in terms of—for instance, when Mr. Kurzman's office indicates that they want testimony developed for a particular hearing, they transmit that information to us. We let the particular agency involved know that we want testimony prepared on a particular issue. We are given that testimony, we review it along with Dr. Zapp and his staff, and ultimately it comes out as the Department's testimony.

Mr. ROGERS. Can you develop your own legislative initiatives, or must they be initiated by the Assistant Secretary for Legislation office?

Dr. EDWARDS. No. Any legislative initiatives that we would develop would obviously have to be approved by the Secretary, and I doubt the Secretary would approve them without at least a consultation with the Assistant Secretary for Legislation.

Mr. ROGERS. I understand that, but what I am asking is can you initiate proposals?

Dr. EDWARDS. Oh, absolutely.

Mr. ROGERS. Do you have that capability in your office or are you building it?

Dr. EDWARDS. Well, we have it. First of all, we have that capability in the agencies, and we are developing a capability to work with them

to develop this kind of information and to pass it on to Dr. Zapp and his group, yes.

Mr. ROGERS. But the presentation would still be made by the Office of the Assistant Secretary for Legislation and not directly by your people? Is that what you are telling me?

Dr. EDWARDS. Well, I think once we make the proposal on a piece of legislation then there would be a number of people that would get into the act. The planning people would get into the act, Dr. Zapp and his group would get into the act, the Comptroller's Office would obviously have to bet into the act in terms of the overall cost of what we were proposing.

Mr. ROGERS. I know about the Office of Management and Budget. You don't have to tell me about that.

Dr. EDWARDS. But at any rate, it becomes a Department strategy and other people get involved in it.

Mr. ROGERS. Well, in other words, it is not so much that you are developing your own legislative capability. That still will remain in the Assistant Secretary for Legislation, I presume.

Dr. EDWARDS. Well, yes and no. I think we in the health field have done a pretty poor job in some areas in developing innovative new programs from a legislative point of view.

Mr. ROGERS. That is why I was asking.

Dr. EDWARDS. We have done some, and I think we have to do a lot better job of that, and I don't think Dr. Zapp would have any problems with this in his office. Would you? I mean I think it is up to the agencies and our office to develop new ideas and new thoughts on this.

Mr. ROGERS. Do you concur in that, Dr. Zapp?

Dr. ZAPP. Yes. I think one of the problems I have seen many times is finding the legislative development and development of the budget all on the same cycle because after awhile you don't know which is the tail that is really wagging the dog. I think more problems have come about as a result of not having the three coordinated rather than who develops them, because ultimately you are going to have most of the same key people.

Mr. ROGERS. But if the Assistant Secretary of Health now has a capability for budgeting, I would presume he would develop a comparable capability for legislation, so that it could be coordinated, as you suggest.

Dr. ZAPP. Yes, because legislative proposals have to be very closely linked to the budget and if you have a good legislative proposal that you develop 6 weeks after the budget comes out, it really has to be something that will get through a supplemental request or it waits until the next fiscal year.

Mr. ROGERS. Thank you. Any other questions?

Mr. NELSEN. Yes, I have a couple.

In the plan of reorganization, is it the feeling that the costs will be lowered or is it really a better delivery of service that you are planning on? Do you feel there would be a dollar savings?

Dr. EDWARDS. I think the reorganization isn't predicated on any dollar savings however, I think it will affect some dollar savings. I think we have eliminated some overhead expenses but any sizable dollar savings will not be made because we are going to have to pick up some of that talent in our office.

Mr. NELSEN. This will mean, more or less, the number of people, bureaucrats, shall we say, here in Washington will be increased, will it not, but this generally is because of the details of the reorganization, as I understood your previous answer.

Dr. EDWARDS. I think the personnel numbers will remain fairly steady. There certainly are no anticipated major cuts in personnel other than those that already were established with the budget.

Mr. NELSEN. Now, dealing with health insurance, you have touched on that and you are assuming, of course, there will be some responsibility for your agency to gear up to the national health insurance. I was out in Minnesota speaking at a committee of the mental health organization and one of the complaints was that for persons who might be receiving treatment at a center the assistance that could be given there under Federal programs was so minimal and not comparable to what might be given in a hospital for other care.

Is there any plan in the future to accommodate this problem?

Mr. LAUR. I think we might need to ask a clarifying question.

Mr. NELSEN. Yes, for example, if a person, one person may be going to a hospital for medical care and, of course, under a Federal program, there may be assistance for them in some instances, but that same person might be going to a community mental health center for treatment of some kind and they get nothing and I wondered if this had ever been discussed.

Mr. LAUR. Mr. Nelsen, I believe that is one of the primary reasons the Secretary, and Dr. Edwards, want to reorganize. One of the questions we considered in reorganizing was how can we assure that the various Federal programs that are enacted, whether they are categorical or not, will take advantage of things such as national health insurance if and when enacted. We want to insure that mental health centers, neighborhood health centers, family health centers, migrant health activities all are conducted in a way which makes it possible for them to be the beneficiary of whatever funding mechanisms become available.

As you have pointed out, that is not the case now and people are at a disadvantage as a result.

Mr. NELSEN. Yes. In our review of the extension of the Public Health Service Act, we found some areas where we felt RMP was working and some felt the comprehensive health planning was working. Much of the testimony indicated a bit of a contest in many areas and now, under this plan, would the two programs be tailored together so we could avoid the duplication, avoid the conflict of delivery?

This is something, of course, we need to consider when we consider extension, looking to the future, and would this be accommodated under your plan?

Dr. EDWARDS. This is certainly an option I think we have to look at. The chairman and I have talked some about this. Our concern is, how can we make our initiative more responsive to the overall health objective? I say ours; yours and ours. I think you pointed out very appropriately that some of the RMP programs had relevance and some didn't, and what we are trying to do—and as you as a committee have said over the next year, you are going to look at these programs and try to develop more relevant programs.

Certainly, one of the things that could be done is how could they work better with such programs as the comprehensive planning and so forth.

Mr. NELSEN. The other day, we referred to the total dollar figure. I didn't mark it down. Dr. Zapp, what was that?

Dr. ZAPP. For HEW?

Mr. NELSEN. Yes.

Dr. ZAPP. I think we were talking in excess of $90 billion, I think, discussing how much of that was controllable and how much was uncontrollable. Eight percent of the budget of the Departnient is uncontrollable. By that I mean it is totally nondiscretionary, not affected by budget grants.

Mr. NELSEN. This means about 12 percent of the moneys available can be used for the programs we have been discussing?

Dr. ZAPP. Right.

Mr. NELSEN. Now, then, the Congress of the United States, quite often authorizes some pretty powerful figures and maybe the appropriation doesn't measure up to our authorization. What percentage of the moneys appropriated is presently held up by OMB and have we appropriated in keeping with our authorization?

Dr. EDWARDS. I would have to supply that for the record. I thought maybe someone from the Comptroller's office was here who could give us those figures.

[The following information was received for the record:]

HEALTH AUTHORIZATION AND APPROPRIATION LEVELS, FY 1973 AND FY 1974

FY 1973 Funds Withheld From Obligation

Following are the answers to Congressman Nelsen's questions concerning authorizations vs. appropriations, and appropriated monies held up by OMB.

In FY 1973, Congressional authorizations for health in substantive legislation were $4,267,000,000 and the maximum amount applicable to these authorizations available under Continuing Resolution was $1,316,786,000 for an authorization/appropriation level of 30 percent. In FY 1974, the authorizations in health legislation were $5,281,600,000 and the appropriations against this authorization level were $1,841,989,000 with a resulting authorization/appropriation of 34 percent.

All FY 1973 funds available under Continuing Resolution that had been withheld from obligation were released December 19, 1973. In FY 1974, HEW has no plan nor intent to withhold any of the funds available in the 1974 Labor-HEW Appropriations Bill over the maximum of 5 percent allowed by Title I.

Mr. NELSEN. I think it is kind of nice to know because it is easy to authorize large amounts but sometimes the appropriation isn't there to do what we may criticize in agency for not doing, I believe if we expect an agency to follow authorization lines then we should appropriate so they may do it, and so that problem falls on our shoulders and it isn't always easy. I want to compliment all of you for being here.

Sometimes I wonder why anybody wants to be in the Government. I have been there myself in an administrative way and it isn't always easy, but I want to say thank you to all of you for your appearance here today and wish you well in your endeavors.

Thank you.

Mr. ROGERS. I might say that the Secretary has submitted a statement to the chairman of the full committee saying that $1.1 billion of

appropriated funds have not been spent in the 1973 fiscal year—$1.1 billion.

Dr. EDWARDS. Yes, which represents in a sense the difference between the continuing resolution and the President's budget.

Mr. NELSEN. I could have used that for our Minnesota medical school.

Dr. EDWARDS. I think, as the chairman knows, the Secretary feels quite strongly that this $1.1 billion has been rather badly distorted. I mean, the reason for this being there, and he is very anxious, as you know, to have a conference with you on it and further discuss it.

Mr. ROGERS. Those are his figures, you know.

Dr. EDWARDS. And they are accurate figures to the extent they do represent the difference between the continuing resolution and the President's—again, this isn't a health issue. It is far bigger than health. It really represents, as you well know, the President's authority to hold down spending and that is over my head.

Mr. ROGERS. We won't get into a discussion of that because the courts are deciding that.

Dr. EDWARDS. That is right.

Mr. NELSEN. Mr. Chairman, I wondered many times if revenue sharing—which is an attractive idea—would take the place of dollars that have been withdrawn in some categorical areas. It would seem to me that we, as Members of Congress, should be giving consideration to what programs are being phased out and then giving States and localities the choice of picking it up with revenue-sharing moneys. We found, for example, in Minnesota, many communities bought bulldozers and fire trucks and some of the programs that we phased out could have been picked up by them and, I think, should have been. I believe that we failed a little bit in not setting guidelines or direction and notification and I hope all agencies give thought to it. Revenue sharing could be a real blessing because you would have a chance to pick and use what you think your community needs and would not be in a position of saying the Federal Government wiped us out because you would have a chance to make that decision out there at the grassroots.

Thank you, Mr. Chairman.

Mr. ROGERS. Dr. Roy?

Mr. ROY. I am still concerned about decentralization and what it will or will not do to congressional oversight. There is a statement, there are serious differences between regional offices and headquarters staff with respect to the manner of achieving objectives.

Can you tell me what those serious differences are between the regional offices and the headquarters staff?

Dr. EDWARDS. I don't know exactly what they are referring to. I do know this, that there are serious differences between headquarters staffs too. In other words, I think that we are going to be in a far better position to resolve some of those issues today or once we get our organizational plan—not this organizational plan, but the organizational plan as it relates to the regions.

I think the fact, just in the health field, that the regional health administrators report to me and not to what used to be the head of HSMHA, will give more clout in terms of allowing us to resolve any differences along policy lines.

Mr. ROY. The statement says headquarters programs have viewed some efforts at integration as obstacles to the achievement of national pragmatic objectives. What I interpret this as saying, and I am sure you will quickly correct me if I am wrong, is that the regional offices feel there is too much emphasis in headquarters of achieving the legislative objectives. Of course, I as a member of this committee, am interested in achieving the objectives set forth in the legislation that we pass.

Dr. EDWARDS. I don't know who was responsible for such a statement, but I think I can say without any hesitation, for all of us here today, that our prime objective is the implementation of these program objectives. I don't think in any way have we suggested that we back off from program objectives.

We merely put together a plan that we think will more directly, or allow us to better address ourselves to these program objectives.

Mr. ROY. Haven't you resolved this conflict in behalf of the regional offices and in essence decreased the power of the headquarters staff? Isn't that really the reason you lost two men?

Dr. EDWARDS. Oh, no, not at all. No, we lost two men—I read it in the paper and I have heard a lot of comments on Dr. Lesser's leaving and the gentleman who is head of HMO. You know, when you reorganize an organization with 27,000 people, as I said this morning, it has a budget of over $2 billion and you only lose two people, I think the accomplishment is a very remarkable one.

You know and I know, having been around a fair period of time, that any time you break up the traditional way of doing things, you are going to step on certain people's toes, and in this case, we had a couple of very able people whom we wanted to stay with us but we broke up their traditional way of operating and they didn't like it and they left.

Dr. Lesser was going to leave anyway, but it made a good newspaper story. Dr. McLeod had other——

Mr. ROY. You and I get different information. I don't know whether the blue sheet is totally reliable on all things but——

Dr. EDWARDS. I hope you don't depend on the blue sheet for your information any more than I should.

Mr. ROY. This is the reason I am referring to it. It says BHME decentralization. Health manpower staffers in the full area were given notice to report to their new regional assignments by the end of August. Another 50 or so out of 210 decided the move wasn't worth it and quit.

Did you lose 2 people or 212 people?

Dr. EDWARDS. First of all, we were talking about two major program directors. Dr. Endicott would like to speak to that. He was in charge of our Bureau of Health Manpower.

Dr. ENDICOTT. Of course, we don't know what the numbers will be at the moment. In order to decentralize some of the BHME programs, we have had to go through our existing staff job descriptions and identify those functions and jobs which would have to be moved to the regional offices.

Mr. ROGERS. Off the record.

[Discussion off the record.]

Mr. ROGERS. On the record.

Mr. ROY. Mr. Chairman, I am greatly concerned that this decentralization objective—I would like to get back to that sometime.

Mr. ROGERS. You go right ahead. I am just saying I think we are going to have to answer the bell here.

Dr. Endicott, you can continue.

Dr. EDWARDS. I asked Dr. Endicott, first of all not only would he address himself to those people that might leave, but also what he is trying to do in the Bureau of Health Manpower by his decentralization.

Mr. ROGERS. I think it might be well to have for the record how many of you are leaving and what other major points should be discussed?

[The following statement was received for the record:]

We are unable to determine how many people left the Department because of dissatisfaction with the Health reorganization for two reasons. First, unless an individual specifically stated disapproval of the Health reorganization as a reason for leaving, there would be no way of determining if disapproval or dissatisfaction with the reorganization was a reason. Secondly, a large number of people throughout DHEW and the Federal establishment retired one day before the Health reorganization (on June 30, 1973) in order to take advantage of the 6.1 percent annuity increase that was available for those retiring before the end of fiscal year 1973.

Mr. ROGERS. Would you like to come back?

Mr. ROY. I would like to come back if these gentlemen have the time. I don't think it will take very long but I would like 10 or 15 minutes.

Mr. ROGERS. Could we answer the rollcall and be right back?

Dr. EDWARDS. Would it be agreeable with you, Mr. Chairman—I have an important appointment at 4 o'clock if Dr. Endicott would stay?

Mr. ROGERS. Do you think Dr. Endicott could answer those questions for you?

Mr. ROY. I am interested in the fact that regional offices receive separate allocations tied to individual appropriations instead of a consolidated operating budget. Under this reorganization, will regional offices receive a consolidated operating budget and if so, how did we then identify moneys appropriated for categorical programs?

Mr. ROGERS. I suppose you can submit that answer too.

Dr. EDWARDS. Well, any way you want.

Mr. ROY. Go ahead and submit that answer to me because we are running out of time on this.

[The following statement was received for the record:]

The Regional Medical Programs are now part of the Bureau of Health Services Research and Evaluation, within the Health Resources Administration. The Allied and Public Health Training programs are within the Bureau of Health Resources Development, also located in the new Health Resources Administration.

Mr. ROGERS. I might say I would also like to know where RMP falls. The Division of Allied Health Manpower and the Division of Nursing were separate parts of the Bureau of Manpower. I would like to know where those would fall in the new agency.

[See chart on p. 52.]

Mr. Roy. And, Mr. Chairman, I would like the response which will eventually be written to the letter of July 26 to the Secretary from the American Association of Foundations for Medical Care with regard to the present plans for the organization of the PSRO service too, because it appears to me that this is also seriously jeopardized by the lack of direct authority on behalf of Dr. Bauer.

[The following statement was received for the record:]

We have ascertained that the letter of July 26 was never responded to by letter, but rather on September 24, 1973, the Secretary met with representatives of the American Association of Foundations for Medical Care to discuss the future of Professional Standards Review Organization. This meeting satisfied the members of the Foundation and therefore substituted for the response to their letter.

Mr. Rogers. Thank you. The committee will stand adjourned until 10 o'clock tomorrow.

[Whereupon the subcommittee adjourned at 3:40 p.m. to reconvene at 10 a.m. Tuesday, July 31, 1973.]

REORGANIZATION OF HEALTH PROGRAMS IN HEW

TUESDAY, JULY 31, 1973

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLIC HEALTH AND ENVIRONMENT,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., in room 2216, Rayburn Office Building, Hon. Richardson Preyer, presiding [Hon. Paul G. Rogers, chairman].

Mr. PREYER. The committee will come to order, and we begin our second day of oversight hearings on the HEW reorganization plan.

Our first witnesses today consist of a panel of two very distinguished and highly qualified gentlement, Dr. Joseph English, who is the former Administrator of the Health Services and Mental Health Administration, and now president of New York Health and Hospitals Corp. It is good to have you with us Dr. English—and Dr. Gordon MacLeod, former Director of the Health Maintenance Organization Service. It is good to have you with us, also Dr. MacLeod.

Our chairman will be in a little later today. He is testifying on the energy blackout in Florida.

We will begin hearing from Dr. English and Dr. MacLeod in whatever form or manner you wish to enlighten us.

STATEMENTS OF DR. GORDON K. MacLEOD, BRONXVILLE, N.Y., FORMER DIRECTOR, HEALTH MAINTENANCE ORGANIZATION SERVICE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; AND DR. JOSEPH ENGLISH, PRESIDENT, NEW YORK CITY HEALTH AND HOSPITALS CORP. AND FORMER ADMINISTRATOR, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Dr. MACLEOD. Mr. Chairman and members of the subcommittee, I am pleased to be able to testify on a matter of great importance to the delivery of health services to the American people. The high management profile of the Department of Health, Education, and Welfare has recently quite often obscured the invaluable professional and administrative contributions of a dedicated bureaucracy. The relentless application of industrial management techniques has demoralized the bureaucracy as manifest by the departure of many key professional personnel from Government service and by several other indicators as well.

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It is almost gratuitous to say that the Government with its vast armies of bureaucratic employees needs strong and effective management. However, application of management principles in Government is not necessarily the same as in the private sector. The authority for Government programs emanates from Congress; and the accountability for the performance of those programs must necessarily be to the legislative branch, albeit by way of the executive branch. In order to be responsive both within the executive and to the legislative branches the concept of the "program" or the "institute" in the case of the National Institutes of Health has appropriately arisen.

There are a good many reasons for program identity in Government service, not the least of which is the need for fiscal responsibility and accountability. A second reason is the need for interaction with the public or private sector. Unlike highly competitive business concerns which usually exercise enthusiastically share its professional knowledge and experience with that segment of the public or private sector it serves. A third reason for program integrity is inherent in the bureaucratic tradition itself. In Government service the ceiling on income, and on the number and the grade level of personnel working in a single program at any one time tends to reverse industrial managerial instincts. Private sector ambitions for personal gain are redirected within the bureaucracy toward program commitment, personal cooperation, and the prestige resulting from professional accomplishment.

Federal administrators must run their agencies and programs with the usual management tools of budget and manpower resources in order to carry out the administration's objectives which are not always the same as those of Congress. A Federal administrator in HEW must be sensitive to the intent of Congress and at the same time be competent to review and report on the professional content and impact of the agency or program, especially during congressional committee hearings. For this reason, the professional competence of agency heads and program directors is of paramount importance in carrying out congressional mandates.

The obvious alternative to professionalism in Government is management without professionalism—or management-for-management's-sake. This approach in HEW, for example, has resulted in the appointment of top management with no health service experience who are called upon to make decisions that relate directly to health and medical care matters.

REORGANIZATION OF HEW

A case in point occurred in the recent reorganization of the Health arm of HEW which was a two pronged effort. First, the long awaited unification of the separate voices of the health establishment within Government was largely accomplished, and was much needed. Heretofore, each of the three major health agencies, the National Institutes of Health, the Health Services and Mental Health Administration, and the Food and Drug Administration, actually reported directly to the Secretary of HEW and each spoke with its own voice, even though the organizational charts belied this; they showed a direct line passing through the Assistant Secretary for Health. Now,each agency head must report to the Assistant Secretary for Health who in turn reports to the Secretary.

As part of the first prong of reorganization, it was decided to restructure the Health Services and Mental Health Administration. The $2 billion budget, and the 27,000 person Health Services and Mental Health Administration was thought to be cumbersome in more than name only. There was little disagreement about the unwieldy size of this mammoth agency even though previous administrators had done an effective job of managing it. One of them, Dr. English, is sitting beside me. In order to correct both the growing size and complexity of the agency it was decided to break it up into three separate agencies called Health Services Administration, Health Resources Administration, and Center for Disease Control. The groundwork for this part of the reorganization had already been laid by Dr. Vernon Wilson, the most recent Administrator of HSMHA.

The benefits of streamlining the superstructure have been almost totally vitiated by the second prong known as decategorization. A management expert was appointed Director of the largest of the three new agencies, the Health Services Administration. Armed only with his management background, he was put in the impossible position of having to design a new table or organization for health services with no experience in the health field. Within 60 days of his appointment it was decided to downgrade or decategorize many well run traditional programs from a substantial activity level to a desk function with 5 to 10 people manning each desk. These included many respected programs primarily for the poor such as Maternal and Child Health Service, Family Planning Service, National Health Service Corps, and the Neighborhood Health Centers, and migrant health programs; the latter two were part of Community Health Services. But the reorganization also lumped the Health Maintenance Organization (HMO) Service with the poor people's programs even though HMO's cut across socioeconomic lines. Most of the professional program leadership had been provided by recognized authorities in the health field; this abruptly came to an end either by resignation or by decategorization. Professional contacts with the private sector are now to be coordinated by junior or middle management working at the desk. The public constituencies of these programs are now adrift in a sea of bureaucracy. The administration of such activities as grants, contracts, and health service delivery will no longer be the responsibility of the program but will report directly to top management without the advantages of a program's fiscal accountability. As yet, there is no clear definition of the role of the regional office staffs.

The major organizational units for this new grouping of poor people's programs are now called policy development, organization development, health services financing, clinical services, and monitoring and analysis. Congress accustomed to responding to public pressure to specific problems would find little value in accountability for any of these categories. Nor would it be worthwhile for them to do so.

On the one hand, the reorganization or decategorization suggests a management effort to begin to organize health services delivery mainly for the poor using the HMO principles of prepayment and capitation payment wherever possible. Some might interpret this policy as propogating two classes of health care, one for the poor and one for the rest of the people. On the other hand, instead of organizing a poor people's health service, Congress has consistently directed

its attention to program activities intended to meet specific health care needs. And, of course, Congress wants to know how well the administration has carried out its legislative mandate.

Under the second prong of the reorganization, it would be almost impossible to determine the cost needs for each desk's functions—formerly a program's responsibility. Thus, it is easy to see how decategorization all but eliminates program activity and impedes accountability.

DECATEGORIZATION OF HMO'S

One example of the consequences of decategorization can be seen in the program for Health Maintenance Organizations. The Federal initiative for HMO development over the past 2 years was based on the 44-year history of prepaid group practice plans and individual practice plans offering individuals and families a voluntary choice of paying a single monthly fee for a comprehensive range of inpatient and outpatient services as an alternative to paying for each and every service. The emphasis on disease prevention, the opportunity for early diagnosis, and appropriate utilization of health care facilities in HMO's have resulted in reductions in hospitalization and in cost containment. Acceptance of the HMO concept by patients and physicians alike is well recognized and the potential impact on the Nation's health is obvious.

Managerial challenges are not new to physicians in HMO's. In the early days of many developing prepaid plans a dedicated group of medical managers weathered storms of social and professional ostracism in order to develop plans which now effectively serve over 5 million people. Thus, American medicine can be cited for an outstanding contribution to medical management.

President Nixon in his health message to Congress in 1971 featured the HMO as central to his national health strategy and rallied support for the concept. The President's continued strong endorsement of HMO's in his 1972 health message prompted the then Secretary of HEW, Elliot Richardson, to urge that the option to join an HMO be made available to 90 percent of the population on a voluntary basis. To implement this activity the Secretary had established a Health Maintenance Organization Service in HEW in October of 1971.

From then until now the HMO service was a focal point in government for vigorous program activity. It provided professional and technical assistance to develop some 20 new HMO's to become operational with an additional 20 to 25 scheduled to begin operating in the next year or so. It also provided assistance to some 10 States which enacted legislation to permit HMO's to operate where they had previously been partially or totally constrained from operating. It has worked closely with highly supportive medical professional groups and others in the private sector including the Association of American Medical Colleges, the American Association of Medical Clinics, the American Association of Foundations for Medical Care, the American Hospital Association, the Group Health Association of America, the National Medical Association Foundation, the Blue Cross Association, the National Association of Blue Shield Plans, the Health Insurance Association of America, and to a lesser extent with the American Medical Association which has been less than enthusiastic in its support of HMO's. These then were some of the accomplishments—including fiscal accountability—of a relatively small program.

Decategorization, the second prong of the reorganization, thus effectively cripples the Federal HMO program by reducing it to a desk function and all but buries the administration's only new health initiative listed in the 1974 budget. With the possibility of HMO legislation in the immediate offing, a full demonstration of HMO effectiveness is now up to Congress. In future health legislation the Congress may have to address the question of whether new Federal authority must include program integrity for purposes of accountability both within the executive branch and to the Congress.

In summary, the subordination of professional activity to management-for-management's-sake within HEW must raise questions of the potential effectiveness of the reorganization currently underway. Moreover, it seems ironic that the new breed of "managers" could fumble in laying the groundwork for some degree of organization of health services primarily for the poor without obtaining prior congressional authorization. Finally, through the decategorization of HMO's the administration is losing a unique opportunity to work cooperatively with the private sector in instituting health care reform in a fashion that to date has proved acceptable to several million people as well as to many thousands of practicing physicians in the country.

That is my statement, Mr. Chairman. I shall be happy to answer any questions.

Mr. ROGERS. Thank you very much. We appreciate your being here and the statement you have given.

The committee is delighted also to welcome back an old friend, Dr. English, who was with the Federal Government and has been performing services in New York. Would you like to make a statement at this time?

STATEMENT OF DR. JOSEPH ENGLISH

Dr. ENGLISH. I would indeed, Mr. Chairman. I want to express my thanks to this committee which was so helpful to us when I had the opportunity to appear here as the Administrator of the Health Services and Mental Health Administration. I welcome this opportunity to comment on the reorganization not only from that perspective which is one of 3 or 4 years ago, but from the perspective of those of us who are working in New York City in what is the largest health care organization outside of the Federal Government in the United States of America. And if the committee would indulge me in providing this perspective to some of the issues you are concerned about, I would appreciate the opportunity using that as a point of departure.

The New York Health and Hospitals Corp. was brought into existence in 1970 by an act of the State legislature to develop a comprehensive health care program for all of the citizens of our city, using largely as the base for doing this the municipal hospital system of New York, which was legendary in terms of its chronic problems of underfinancing and understaffing which it had suffered through the years. This system is now composed of some 19 hospitals which have 16,000 beds. These hospitals last year provided 4½ million inpatient days of care to the citizens of New York City, 3 million outpatient visits, and 1½ million emergency room visits. Within those generic categories, there are a quarter million psychiatric emergency room visits, 25,000 days of psychiatric day care, 200,000 outpatient drug addiction visit services and 2,300 patients under home care. We

delivered in our hospitals last year 29,000 babies; we performed 109,000 surgical procedures; we filled 8 million prescriptions, and we performed 24 million laboratory tests. We are major provider of care to nearly 2 million people in the Nation's largest city.

In addition to that, we operate the ambulance system for the city of New York. We have at this moment 100 ambulances on the streets of the city of New York, and during the course of this hearing we will dispatch an ambulance (every 58 seconds) to serve a New Yorker somewhere within the bounds of our city.

I mention all of that to give you some idea of the scale or our operation—the fact that we are now the second largest employer in the city of New York, employing directly and indirectly some 60,000 workers. Included in that are 6,000 physicians and 6,200 registered nurses.

To give you some feeling for the perspective I bring to this committee this morning, 4 months ago we were threatened with the withdrawal of better than $13 million in Federal grants, many of which support vital services in our hospitals; many of which are within the jurisdiction and concern of this committee. If it had not been for congressional initiatives, for which we are so grateful, which resulted in the last couple of months in restoration of many of those funds, we would be at this moment preparing to lay off 1,200 people in the city of New York—many of them, for example, involved in outpatient care and providing pediatric services under grant programs at Bellevue and other hospitals in New York City.

So the first thing I want to say now is that we are grateful for the concern that you are manifesting, and that it is beginning to turn back threatened grant withdrawals which would have faced us in the city of New York with great hardship.

You must understand this is not the loss of new grant moneys that we have been applying for, but $13.5 million of grant support that we presently receive.

But we still face an issue that may not be as well known to this committee, and I think it has great relevance to this reorganization. We have at Metropolitan Hospital, one of our largest hospitals in New York City—it serves East Harlem and a significant part of the Manhattan community—a beautiful new building that we have been working on for years, a new community mental health center that is going to serve that population. As of this moment because of Federal funds that you have authorized, that have been appropriated, but which are not going to be made available to us, six floors of that new building are going to stand empty for the indefinite future, to the eternal consternation of that community; three of those floors being for critically important mental health research where the moneys at the moment don't seem to be forthcoming, and therefore we have no resources with which we can use a portion of this new facility.

Three other floors which were for the expansion of the traditional psychiatric service in the community mental health center through a staffing grant, which we have been told is not going to be made available to us, are also going to stand empty. So what we are now faced with doing is moving the traditional outpatient department services for Metropolitan Hospital into that building. They will benefit from the new facility, but we will be dealing in the years ahead with the consternation and lack of understanding in the com-

munity that six floors of this new facility will stand empty because promised funds that we had looked forward to receiving we have, at this moment, no hope of receiving.

But even that kind of problem, Mr. Chairman, pales before the major financial issue which we face, which is the fact that the new regulations that have been made possible by H.R. 1 and which the State is now implementing in relation to medicaid face us with an $80 million revenue shortfall in our corporation in this fiscal year.

The problem of paperwork in collecting, for the services that we provide in our hospitals, medicaid and medicare reimbursement is not great enough. We only push 30 million pieces of paper a year now in our hospitals, with thousands of people having to work on this paper, and we are spending an estimated $20 million a year that ought to go to health services to push that paperwork to bring in the reimbursement needed from medicaid and medicare. The new medicaid regulations are going to take a 4-page medicaid form and turn it into 10 pages. I would love to present to you a detailed report on what these regulations are going to do to the time of our doctors and nurses pushing paper instead of giving care. The bottom line of it is that it is going to face us with an $80 million deficit this year which is going to cause serious problems in health care delivery in the city of New York.

And it is with those kinds of problems that I take a look at this reorganization that is being considered by you today.

The first thing that I would say about this reorganization is that in many ways in terms of the problems we face in the cities of this country, and which we face in a very vivid way in New York City, this reorganization does not go far enough. To whom in the Federal health establishment with real authority can I take a problem which faces us this year with a magnitude of $80 million? The fact of the matter is that the Assistant Secretary for Health in the final analysis has practically nothing to do with the policies that result at the State and local level in decisions that can affect health care that massively. I will respect a reorganization of the Federal health establishment only when the Assistant Secretary for Health has policy purview and is in a position to be part of the decisionmaking process involving that kind of massive impact, not just in New York City, but in other cities of our country. It seems to me that that is the essence of what the Federal health reorganization must be all about.

It is tremendously helpful that we can have our grant programs restored, and that through congressional initiative the will of Congress may be enforced there. But I would suggest that if we are to have a national health strategy, if we are to have strong Federal health leadership, then we must bring all the parts of the Federal health establishment together, and at least to some extent, under the purview of this committee, because this committee of the Congress knows something about the problems of the delivery of health care, about health manpower, about the development of new knowledge. And it seems to me that there ought to be some organization of the Federal branch of government that permits you to have that purview when it can affect us as deliverers of health care as massively as some of the recent decisions will.

It seems to me that what the present reorganization attempts to do is something which I think is very much in the interest of health care in this country, which is to produce for the first time a strong

Assistant Secretary for Health who begins to be master of his own house. I think how effectively that reorganization is utilized in the interest of the public need and health care in this country is largely more a function of the people involved than it is the actuality of the structure. And it seems to me that Dr. Edwards in the statement which he has made, where he has been absolutely frank about the fact that we have no national health care strategy, where he has pointed out the limitations of his purview over medicare and medicaid, could conceivably be the strong Assistant Secretary for Health that could begin to engage on these issues.

For him to do that, I think he must first be strong in his own house, and I think he must be able to make his way through this extraordinary bureaucratic maze where he must deal with the comptroller of HEW, where he must deal with the planning office of HEW, where he has to deal with the management offices of HEW, and where ultimately he has to deal with OMB. And the first view I take of this reorganization, other than that it is incomplete, is the extent to which it strengthens his hand internally. For this reason, I would endorse it and it would be very difficult for me to second-guess his reorganization plans, because I would not have liked him to do that when I was to some extent in a comparable position in relation to HSMHA. Rather I think the effort of this committee should be to call him to accountability for how in this strengthened position he is going to assist an administration that has ignored the intent of the laws of the land as they have been passed by the Congress, and has ignored the appropriations that have been made. I am glad to see that this committee is surfacing the fact—that better than $1 billion that we desperately need in the cities of this country as of this moment has not been spent.

I think it is going to take a strong Assistant Secretary to make sure that proper accountability in relationship to this comes to this committee and that these issues can surface before we suffer the agony that we have in New York City while suspecting that such an impoundment had occurred.

There is another part of this reorganization, however, about which I am most critical, most skeptical, and which I think is politically motivated. And that is the regionalization thrust of the Department in attempting at a time when there are very few discretionary moneys to try to apportion those out without any possibility of national priorities being realized through regional offices. My own feeling is that the primary thrust behind that regionalization effort is political.

I remember the early days of the Nixon administration when I was the Administrator of the Health Services and Mental Health Administration. I think we are seeing brought to fruition now more of a threat to national programs then was attempted then. It was my experience as the Administrator of HSMHA that it was almost impossible to get the kind of professional talent, professional talent represented by Dr. MacLeod, and the solid professionalism that national program leadership can bring to the Federal service—you just cannot get that kind of talent in the regional offices for obvious reasons. And if this committee were to examine the qualifications of people that the regional offices have been able to recruit in comparison to the kind of talent that one can attract to national efforts and national programs you would see testimony to this kind of problem.

And I think it is as much as anything else this regionalization effort that is driving that talent that has taken the Federal Government years to attract to Washington out, and I think that is a national tragedy.

Also, I think you are going to find that people that are in the present national program leadership are not going to move to these regions, and so you are not only not going to not have them in the regions, but you are not going to have them in the national program leadership either. That is a real loss to the national interest and the role that the Federal Government has in improving health care services.

Also, I don't think there is any question that when that kind of delegation is made to the regions the issue of accountability not only to the executive branch, but to the Congress, is made infinitely more difficult.

And finally, in terms of my experience in dealing with the regional office in a very different way as the president of a corporation in New York City in contrast to my former dealings as the Administrator of the Health Services and Mental Health Administration, I can tell you that the relative timidity in the regional office, their greater vulnerability to political pressures, results in a qualitatively different level of innovation than the kind of thing the Federal programs ought to be used for. It seems to me that this is the most serious problem with the reorganization.

I think that before this committee endorses anything of this kind of effort it ought to look into all of the dimensions that may be involved in this thrust. I think this is particularly important when the amount of moneys available is so small and when it is so difficult to have any kind of a solid and substantial national effort to improve health care.

Mr. Chairman, I appreciate the opportunity to make these remarks to the committee.

Mr. ROGERS. Thank you very much, Dr. English and Dr. MacLeod.

In his testimony, Assistant Secretary for Health, Dr. Charles Edwards, did say that he was trying to bring about some input from his office to the medicare and medicaid field which I understand you very definitely think should be done. I think most on this committee feel that should be done, and it is encouraging that they are making some movement. I don't think it has yet been finally decided, but the movement seems to be that way. And certainly we would want to encourage that in any reorganization, as you say.

Mr. Carter?

Mr. CARTER. Thank you, Mr. Chairman. You really think the regional concept will not work, is that correct?

Dr. ENGLISH. Yes, sir. And I say that as a former Administrator of one of the Federal agencies most affected by regionalization. But I say, having been out in the boondocks for 3 years and having watched the recruiting abilities of the regional offices and their way of being able to manage what are largely national programs, and my own feeling, quite frankly, Mr. Carter, is that it is going to be more difficult for national program efforts of the Federal Government to be accountable to the Congress, to receive the support which I think professionals around the country want them to receive, to report on their efforts if the regionalization program goes ahead. It is my submission to this committee, having been involved in the early days of the administration, that this thrust is largely political, and that it

is much easier to achieve political control of national program efforts if the real decisionmaking authority is put out in the regions and effectively out of the control of the national leadership which is directly accountable to the Congress and directly accountable to the national organizations which are concerned about this; and I really feel that it is not on the basis of sound management, if you look at the substantive issues involved in these programs that this thrust is receiving such priority, but it is in contrast a part of the political strategy of the administration to pay little heed to the concerns of health care in this country and that the regionalization process in effect is an important part of that strategy.

Mr. CARTER. Do you mean that they want to place politicians in these regional offices? Is that what you mean by political movement?

Dr. ENGLISH. Mr. Carter, I can tell you that in the early days of the administration that was part of the reason why the regionalization effort began at that time. The first attempt was to politicalize the agencies of health in Washington, but it was clear that that was going to be very difficult to acheve for a variety of reasons. And so while that process was in difficulty there was an attempt to move out under largely political auspices in the region the decisionmaking process and, in effect, to establish political control and to reduce, in effect, the political support for these national programs through that decentralization process. And I think that any objective view of the management issues here would suggest that from a substantive standpoint many of these national programs are managed much better in a very different kind of way, and that the real issue involved in the decentralization movement has nothing to do with good management, but is largely part of a political strategy which reflects the priorities of this administration in relationship to health care.

Mr. CARTER. And you think that any appointee to such a regional position would have to have political clearance, is that correct?

Dr. ENGLISH. Yes, sir. That was certainly true when I was the Administrator of HSMHA. As a matter of fact, the strategy at that time—and I am not totally current on it—was that we would have a regional health director, you see, who was the professional in the region, but he was subordinated to an assistant regional director for health who was clearly a political appointee in that regional office. And I am not totally current as to what the current concepts are, but I know for a fact that a very important part of that strategy would be easier political control over the professions in 10 regions than the kind of political damper that can be put on national program heads.

Mr. CARTER. You think you would have difficulty in moving men capable of handling regions out to the regions, is that correct?

Dr. ENGLISH. Yes, sir. I think that, to be quite frank with you, part of the reason why we have been able to attract to the Federal Government men and women of the caliber and the dedication of Dr. MacLeod and others that have been distinguished in Federal service, despite the fact that the pay isn't very good and the problems are great, is because they can exercise some national leadership in relationship to Federal programs. To try to attract that kind of talent to a regional office is virtually impossible, and if this committee were to take a look at the staffing of the regional offices at the moment you would see evidence of that. If you take a look at how many people that have served with distinction in Washington that are willing to move

out at all levels into regional offices you will see the problem there. And I think that it is very clear that it lowers the level of the Federal effort not only to mediocrity, to much poorer administration, but in my judgment, to greater political control which really represents a political damper on these programs which are so needed.

Mr. CARTER. Are you quite familiar with the Atlanta region?

Dr. ENGLISH. Not as—I have been out of the Federal Government now for 3 years, Mr. Carter, so that I couldn't speak to it as of today.

Mr. CARTER. They have some career public health officers down there, do they not?

Dr. ENGLISH. Yes, sir; I believe they do.

Mr. CARTER. Were they sent because of their political clout or affiliation?

Dr. ENGLISH. No, sir; I would suggest that you must look above the career level officer in the regional office to see where the real accountability is in the region, and I would suggest that you would find that they are now almost without exception political appointees.

Mr. CARTER. I must agree on that. I have found that to be true in some cases. Now about your funding, I would like for you to go over that again. Just from what sources did you lose those funds, if you please, sir?

Dr. ENGLISH. I would be happy to submit, Mr. Carter, to the committee a detailed report of the $13½ million of Federal grants that we were threatened with the loss of until fortunately some of the congressional initiative for which we are so grateful. They were grants from the Health Services and Mental Health Administration, from the Bureau of Health Manpower Education, from the National Library of Medicine, as well as from Model Cities, from HUD, and some of the other large Federal programs. So I would be happy to submit to the committee a detailed list of those threatened losses that we had.

[Testimony resumes on p. 91.]

[The report memorandum referred to follows:]

NEW YORK CITY HEALTH AND HOSPITALS CORP.,
OFFICE OF THE PRESIDENT,
New York, N.Y.

MEMORANDUM

To: Deputy Mayor (Hamilton) City of New York.
From: President (English) New York City Health and Hospitals Corporation.
Subject: Withdrawal of federally funded grant support to Health and Hospitals Corporations institutions.

The Health and Hopsitals Corporation is facing a financial dilemma of overwhelming proportions as a consequence of the actual (and threatened) withdrawal of Federally-funded grant support to our nineteen hospitals and affiliated institutions. This situation is compounded by the fact that health care providers throughout the City are turning to the Corporation as the means of solving their financial problems resulting from similar cutbacks in Federal funds. The Corporation feels a moral obligation to not only inform the City Administration of what programs are in jeopardy by virtue of such losses of Federal support, but also to seek guidance in what assistance the City will offer to alleviate a most critical situation.

While there has been no definitive compilation of funding cutbacks in health for the City as a whole, it would be beneficial to project from what the Corporation anticipates is the potential withdrawal of Federal funds impacting on its own capacity to deliver health care. Presently, it is estimated that Federal grants to Corporation hospitals for Fiscal Year 1973 total at least $15,469,113, with grants to affiliate institutions (for work being carried out in Corporation hospitals) totaling at least an additional $7,803,052; attached as Appendix I is a list of such

grants by hospital and by hospital/affiliate. Given that the Corporation has only recently been in the position of compiling the list of grants and believes it to be incomplete, the total figures for grant funds are probably understated. The Corporation anticipates, based on information that certain programs appear to be particularly vulnerable to cutbacks or terminations, that $8,520,124 of grant support could potentially be lost. This includes programs funded by the Department of Housing and Urban Development (DHUD) through the Model Cities program and by the Department of Health, Education and Welfare (DHEW) through the following sources:

Health Services and Mental Health Administration (HSMHA);
Bureau of Health Manpower Education (BHME);
The National Library of Medicine; and
Regional Medical Program (RMP).

The following chart represents Corporation-related Federally-supported programs in danger of partial or total funding cuts for Fiscal Year 1974.

CHART I.—FEDERALLY SUPPORTED PROGRAMS IN DANGER OF PARTIAL OR TOTAL FUNDING CUTS FOR FISCAL YEAR 1974

Hospitals and program	Funding source	Fiscal year 1973 budget
Bellevue Hospital Center:		
X-ray technician training	DHUD Model Cities	$130,825
Pediatric embulatory care	HSMHA	1,880,000
Total		2,010,825
Cumberland Hospital, Brooklyn Hospital: Renal dialysis (total)	RMP	18,554
City Hospital Center at Elmhurst; Mount Sinai Hospital: Medical library resource grant (total)	National Library of Medicine	2,562
Gouveneur Hospital: Staffing-ambulatory care program (total)	HEW	1,740,000
Greenpoint Hospital, Brooklyn Jewish Hospital: Medical library resource grant (total)	National Library of Medicine	1,581
Harlem Hospital Center:		
Ambulatory detoxification	Model Cities	138,368
PN to RN nurse training	do	168,000
Laboratory technician training program	BHME	20,000
Nursing capitation	BHME	37,426
Financial distress grant	BHME	480,379
Hospital administration	Model Cities	53,326
Total		897,501
Harlem Hospital Center, Columbia College of Physicians and Surgeons:		
Medical library resource grant	National Library of Medicine	33,840
Nursing scholarship/tuition	BHME	46,896
Do	BHME	33,689
Harlem regional program for stroke and hypertention	RMP	320,000
Total		434,423
Kings County Hospital Center:		
Comprehensive health care (East New York Family Center)	Model Cities	586,726
X-ray technician training	do	403,441
LPN training	do	521,046
Alcoholism	do	330,000
Capitation-student loan program	BHME	45,000
Nursing student scholarship program	BHME	20,000
Nursing capitation grant program	BHME	114,767
Total		2,020,960
Metropolitan Hospital; New York Medical College: Public health traineeship.	BHME	4,512
Total		4,512
Morrisania Hospital: Ambulatory detoxification	Model Cities	132,758
Total		132,758
Morrisania Hospital; Montefiore Hospital: Comprehensive Health Care Center.	HSMHA	910,000
Total		910,000

CHART I.—FEDERALLY SUPPORTED PROGRAMS IN DANGER OF PARTIAL OR TOTAL FUNDING CUTS FOR FISCAL YEAR 1974— Continued

Hospitals and program	Funding source	Fiscal year 1973 budget
Queens Hospital Center:		
LPN training	Model Cities	61,926
Student nursing loan	BHME	14,000
Nursing scholarship	BHME	7,000
Total		82,926
Queens Hospital Center; Long Island Jewish Hospital: CARE (comprehensive ambulatory rehabilitation experience).	RMP	97,500
Total		97,500
Sydenham Hospital: Comprehensive dental care	Model Cities	166,000
Total		166,000

The above information has been gathered from summary presentations of the President's Fiscal Year 1974 Budget (Federal), rather than by examination of the line-by-line amounts proposed for particular programs. It should also be kept in mind that changes in the administration or distribution procedures of grant funds may effectively reduce some programs even further; since these changes are not yet apparent, they are not reflected here.

In addition, there are nine Neighborhood Health Centers providing health care on an ambulatory basis in New York City which are critically dependent on Federal grant funding. Seven of the nine operate under the aegis of the Department of Health, Education, and Welfare under 314(e), Project Grants for Health Services Development legislation; two of the nine operate with Office of Economic Opportunity (OEO) funding. To date, an estimated $2.3 million in Federal grant funds have been scheduled for withdrawal from the seven 314(e)-funded centers, which could transfer anywhere from 15,000 to 40,000 additional ambulatory visits to the Corporation within the next calendar year, at a cost of from $0.5 to $1.4 million to the Corporation over the next 12 months, not reimbursed by either the State or Federal governments. These estimates do not include any workload from the two OEO Centers since no cutbacks have been implemented to date, nor do the above estimates include anything other than already announced 314(e) reductions. Potential annual cost to the Corporation, however, should the Federal government completely eliminate its grant support to all nine centers within the coming 12 months, is from $4.0 million to $8.5 million.

Further, the Corporation faces a massive withdrawal of Emergency Employment Act funding. At the request of the City, the Corporation initiated a rather extensive EEA program in its institutions and centrally, which has currently 487 individuals in EEA-funded jobs. It has now been announced that the Welfare Demonstration Project will terminate on 30 June 1973 and that there is an indefinite future for Sections 5 and 6 under the EEA program. Thus, the Corporation's local institutions must either absorb the cost associated with placing these individuals in Corporation jobs or terminate EEA employees, many of whom have not only personally benefited by their jobs but who have also benefited the hospitals by their work contribution.

In brief, the Health and Hospitals Corporation does *not* have sufficient resources to assume these withdrawals in Federal funding. Operating under what is considered to be an insufficient Fiscal Year 1973 Expense Budget of $796 million to meet basic program needs, the Corporation is unable to assume the costs of programs experiencing actual or threatened Federal withdrawal of support. Consequently, the Corporation is appealing to the City for guidance and financial relief.

Much has been said about "Revenue Sharing" as the replacement for categorical grants and as the rational financial solution to urban problems. To our knowledge, New York City received approximately $213.7 million in general revenue sharing monies from the State in 1972. This $213.7 million was used for public transportation ($100 million), Police and Fire Department ($78.3 million) and Environmental Protection and/or Sanitation ($25.0 million). Since this money was borrowed from the State before payments were received from the Federal government, the City's use of its funds was prescribed in the State legislation authorizing

the loan. It would appear, however, that the City has yet to develop a plan for the use of 1973 General Revenue Sharing funds—such plan to be developed during April or May of this year. Accordingly, the Corporation is imploring the City to consider its plight and the plight of all health care providers throughout the City when developing the General Revenue Sharing plan for 1973.

In addition, the Corporation is formally requesting an immediate increase to the Health and Hospitals Corporation Fiscal Year 1974 Expense Budget Request in the amount of $13.947 million, raising the total request for Fiscal Year 1974 from $1,063.374 million to $1,077.321 million, with all additional funds to be from City Tax Levy other than Medicaid Tax Levy, Debt Service Tax Levy, or by Tax Levy funds made available by contract with the Department of Mental Health and Mental Retardation Services. The derivation of this additional request of $13.947 million is explained in Appendix II.

The City of New York and the Health and Hospitals Corporation cannot afford to let the residents of this City be without vitally needed medical care. Arrangements must be made for alternative means of financing to fill the void created by the withdrawal of Federal support. Unless new funding is found, the Corporation (and the City of New York) will be unable to pursue the course toward improving the health and hospital care for the citizens of this great city.

Sincerely yours,

JOSEPH T. ENGLISH, M.D., *President.*

Attachments.

APPENDIX I

Hospital:	*Fiscal year 1973 Federal grant funds*
Bellevue Hospital Center	$2, 868, 856
Bronx Municipal Hospital Center	153, 872
City Hospital Center at Elmhurst	855, 702
Coney Island Hospital	1, 731, 000
Francis Delafield Hospital	830, 351
Fordham Hospital	37, 425
Gouverneur Hospital	[1] 1, 740, 000
Greenpoint Hospital	368, 967
Harlem Hospital Center	1, 942, 153
Kings County Hospital Center	2, 286, 367
Lincoln Hospital	955, 899
Metropolitan Hospital Center	923, 570
Morrisania Hospital	413, 585
Queens Hospital Center	195, 366
Sydenham Hospital	166, 000
Total	15, 469, 113

[1] A reduction of $260,000—from $2.0 million—already imposed.

The list of grants to affiliate institutions with work being carried out at Corporation hospitals indicates at least $7,803,052 for Fiscal Year 1973, as follows:

Corporation Hospital/Affiliate:	*Fiscal year 1973 Federal grant funds*
Bird S. Coler Hospital/New York Medical College	$51, 855
Cumberland Hospital/Brooklyn Hospital	70, 849
Francis Delafield Hospital/Columbia College of Physicians and Surgeons	1, 432, 613
City Hospital Center at Elmhurst/Mount Sinai Hospital	320, 568
Goldwater Memorial Hospital/New York University	76, 500
Greenpoint Hospital/Brooklyn Jewish Hospital	1, 581
Harlem Hospital Center/Columbia College of Physicians and Surgeons	1, 607, 012
Kings County Hospital Center/Downstate Medical Center	1, 921, 624
Lincoln Hospital/Albert Einstein College of Medicine	78, 790
Metropolitan Hospital Center/New York Medical College	1, 075, 398
Morrisania Hospital/Montefiore Hospital	920, 000
Queens Hospital Center/Long Island Jewish Medical Center	246, 262
Total	7, 803, 052

The list that follows represents those programs which appear to be particularly vulnerable to cutbacks or termination, based on present information.

The list includes programs funded by the Department of Housing and Urban Development (DHUD) through the Model Cities program, and by the Department of Health, Education, and Welfare (HEW) through the following sources: Health Services and Mental Health Administration (HSMHA), Bureau of Health Manpower Education (BHME), the National Library of Medicine and the Regional Medical Program (RMP).

APPENDIX II

Derivation of the Request To Increase the Health and Hospitals Corporation, Fiscal Year 1974 Expense Budget Request by $13.947 Million

The $13.947 millon additional request is comprised of the following pieces:

$4.027 million to cover the cost of the Emergency Employment Act Program (EEA) currently in operation. As of March 1973, EEA individuals employed represented a total salary cost of $3.533 million plus $0.494 million in fringe benefits. Of this total, $1.320 million in salaries plus $0.185 million in fringe benefits will definitely be withdrawn on 30 June 1973 with the end of the Welfare Demonstration Program—and the remaining $2.522 million (representing $2.212 million in salary costs and $0.310 million in fringe benefits for Sections 5 and 6 of the EEA program) is in real jeopardy of losing funding.

$1.400 million to cover the costs associated with the transfer of between 15,000 and 40,000 additional ambulatory visits to the Corporation resulting from the withdrawal of Federal grant funds to the Neighborhood Health Centers in New York City. It should be remembered that the estimated potential cost to the Corporation, should all Federal grant support to these programs be cut off, is from $4.000 million to $8.500 million.

$8.520 million to cover the costs associated with the Corporation assuming funding responsibility for all the Federally-supported programs listed in Table I as programs in danger of partial or total Federal funding cuts for Fiscal Year 1974. While it may appear to be unrealistic to consider that all of the programs listed will totally lose their funding, it is realistic to keep in mind that this list is probably incomplete and that the workload increase to the Corporation facilities, generated by loss of Federal funding for similar programs to the other health care providers in the City (not to mention the potential impact of H.R.-1 on the voluntary hospitals) will more than amply make up for any pessimistic overestimation. It should also be notes that the Model Cities programs are retained in the listing of programs threatened with Federal funding cut-backs, since the Corporation has received no indication that funding for the continuation of these programs will receive final approval from the Department of Housing and Urban Development.

Dr. English. I would also be very happy to submit to the committee the changes in the medicaid regulations that have been permitted by H.R. 1 by the amendments to medicaid in the last session of the Congress which are now presenting us with the possibility of an $80 million revenue shortfall this year as a result of those changes.

[The testimony resumes on p. 105.]

[The following information was received for the record:]

Analysis and Discussion of the 1972 Amendments to the Social Security Act (H.R. 1)

INTRODUCTION

The 1972 Amendments to the Social Security Act, commonly known as H.R.-1, became Public Law 92-603 on 30 October 1972. Containing 95 provisions that directly affect the Medicare and Medicaid programs, the law will impact significantly on the present and future financial condition of the Health and Hospitals Corporation. By limiting population coverage, potentially restricting program benefits, and imposing stringent requirements for reimbursement, these health amendments move toward controlling the rising program costs of Medicare and Medicaid for the Federal and State governments, to the detriment of the providers of care and of the poor, aged, and medically indigent population.

Medicare coverage is expanded to include disabled Social Security beneficiaries and those aged 65 and over previously ineligible for the program. Disabled individuals, however, are only entitled to Medicare after they have received Social

Security disability payments for 24 months. Those previously ineligible for Medicare would be given the opportunity to enroll, but only after a prohibitively great cost to themselves.

Medicaid coverage, on the other hand, is limited by the law mandating that those individuals classified as "medically indigent" (above public assistance level, but below the allowable income level for medical assistance) contribute toward a monthly premium in order to be considered enrolled in the program. Given the unlikelihood that a medically indigent person will be able to afford the premium payments, many people falling into this category will be left with little or no health care coverage. Certainly this provision will not provide an incentive to voluntary institutions already verging upon insolvency to readily admit poorer patients, thereby predictably shifting the financial burden to the municipal hospital system.

The benefit structure of Medicare and Medicaid also is greatly affected by H.R.–1. States are no longer required to move toward a comprehensive Medicaid program, as originally called for by the enabling legislation. States are, in fact, able to reduce the range of non-mandated services without being held to the current "maintenance of effort" requirements. It is quite reasonable to expect that states, given their own budgetary problems, will be receptive to the idea of reducing the benefit packages offered under State Medicaid programs, quite possibly reducing benefits to the basic health services mandated by Federal law. The original intent of the Medicaid legislation—namely, to make a meaningful program of medical care services available to the needy population—potentially could be destroyed by these sections of H.R.–1.

The changes called for by H.R.–1 in the financing and reimbursement aspects of Medicare and Medicaid will have very serious consequences for both the recipient and the provider. Recipients are forced to assume a greater role in cost-sharing in the programs. Medicare beneficiaries face an increased annual deductible for Part B medical services, in addition to increased coinsurance charges. Medically indigent recipients of Medicaid are required to pay a premium before qualifying for coverage under the program. States are allowed to impose coinsurance and deductible charges on medically indigent individuals for all services and on public assistance recipients for non-mandatory services. Providers must meet greater requirements for utilization and review before reimbursement will be tendered for services rendered. All claims will be subject to Professional Standards Review, a quality control mechanism that most assuredly will greatly curtail the reimbursement from these programs to medical care institutions.

In short, the provisions of H.R.–1 succeed in substantially shifting the financial costs of the Medicare and Medicaid program to the poor and aged recipients as well as to the providers of health care.

The above discussion is merely a brief overview of the H.R.–1 provisions and the impact they will have on the Medicare and Medicaid programs. In order to more fully appreciate what the consequences of this legislation will mean for the Corporation, a detailed description and analysis of various sections of Public Law 92–603 is presented in the following pages. This analysis is broken down by general categories of particular significance to the Corporation, as follows:

Professional Standards Review.
Utilization and Review.
Expansion of Eligibility.
Expansion of Services.
Cost-Sharing by the Recipient.
Skilled Nursing Facilities—Extended Care Facilities.
Cost Control.
State Funding Restrictions.
Health Maintenance Organizations.
Demonstration Funds.
Public Disclosure.
Miscellaneous Provisions.

PROFESSIONAL STANDARDS REVIEW ORGANIZATION

Section 249–F. Professional Standards Review

The objective of Section 249–F of H.R.–1 is the promotion of effective, efficient and economical delivery of health care services of proper quality, for which payment will be made under the Social Security Act. The application of the mechanism of professional standards review created under this section is meant to en-

sure the following with regard to reimbursable services under the Medicare, Medicaid, and Maternal and Child Health programs:

That services conform to appropriate professional quality standards for the provision of health care;

That payment is made only when the services is determined as being medically necessary; and

That payment is made only when inpatient service is not of excess length and could not have been provided more effectively/economically on an outpatient basis or in a health care facility of a different type.

The realization of these objectives is to be accomplished through the use of Professional Standards Review Organizations (PSRO). By January 1974, the Secretary of Health, Education and Welfare (HEW) is authorized to establish geographically defined medical service areas throughout the nation, areas for which PSRO's are to be designated. A PSRO is to be a nonprofit professional association composed of a substantial number (usually 300 or more) of licensed physicians from the area. It will be the responsibility of the PSRO to review the professional activities of area physicians and institutional and non-institutional providers of health care services for which payment is made under the Social Security Act. As stated, the review must determine whether (1) the services and items were medically necessary, (2) the quality of such services meets professionally recognized standards of health care, and (3) the services provided in an institution could have been provided on an outpatient basis or more economically in a different type of facility. The PSRO also has the authority to determine, in advance, the necessity and appropriateness of elective hospital admissions or any other health care service which involves prolonged and/or expensive treatment. Physicians responsible for the review of hospital care must have active hospital staff privileges in at least one of the participating hospitals in the area served by the PSRO. No physician, however, will be allowed to review care and services provided in any hospital in which he has active staff privileges or in which he has any direct or indirect financial interest. Should the PSRO disapprove the service it has reviewed—and the review can be either on a retrospective or prospective basis—no claims for reimbursement of that service will be paid. Further, the Secretary of HEW, on the recommendation of the local PSRO, can suspend, terminate or levy fines on providers who fail to comply with the provisions of this section.

In short, Section 249–F is meant to serve as both a quality and cost control mechanism, with an association of local physicians monitoring all health care providers within a certain area as to performance in terms of both quality and cost control. Based on regional standards of health care and diagnostic and treatment standards set up by a National PSRO Council, each local PSRO is responsible for evaluating how well each local provider is meeting these standards. If these standards are violated, the local provider will be penalized by having the claim for service disallowed.

Originally, the American Medical Association (AMA) strenuously opposed the PSRO concept because of its implications of "peer review" and other points which it considered unprofessional, degrading, and financially hazardous. The AMA has now decided to play a dominant role in the implementation of the PSRO program and has established a PSRO advisory committee charged with the responsibility of assisting in the preparation of rules and regulations governing the PSRO program and developing recommended operating procedures. All this is being done, clearly, to safeguard the interests of medical specialties and of the medical profession in general during the development of the health care standards required under the H.R. 1 legislation.

From all appearances, however, it would seem that hospitals have not currently taken an active role in protecting their interests. The implementation of this section could have disastrous financial consequences for any institution which does not have sufficiently strong internal utilization and review mechanisms.

While it is impossible to estimate the financial impact this section could have, because of lack of past experience with PSRO's and the unknown nature of the still to be developed health care standards, the Health and Hospitals Corporation will be affected by the financial implications of PSRO's for two reasons. The first is that the Corporation overall has not had utilization and review performance in its nineteen hospitals.

The second reason why the Corporation is particularly vulnerable to the concept of PSRO's has to do with the regional standards that will be established by the National PSRO Council. Given the health characteristics of the patient population served by the Corporation, the great use of many of its facilities, and the budgetary limitations imposed on it by the City, it would be discriminatory

to force the Corporation to be subject to the same standards for care, diagnosis, and treatment, without respect to differences in patient characteristics, as other institutions in this region.

It therefore becomes imperative that the Corporation petition the Secretary of HEW to allow the Corporation to be designated as its own PSRO region and also as its own PSRO. Accordingly, the Corporation should formally request the assistance of the Secretary of HEW in the preparation of a formal plan for becoming a PSRO. The Secretary is obligated to offer technical assistance to any physician association which expresses a desire to become a PSRO and which, in the Secretary's opinion, has the potential to fulfill the requirements and satisfactorily perform as a PSRO. Furthermore, discussions should be held with the Secretary to pursue the matter of having the Corporation designated as its own discrete area to which such PSRO will be assigned. The importance of immediately requesting the above is to take the initiative in what is currently a highly undefined and confused area.

A crude estimate of the consequences of PSRO's, based on current Corporation Medicare/utilization and review experiences, could be disallowance of up to $20 million per year in currently approved claims; the costs of a PSRO should approximate $6 million a year.

UTILIZATION AND REVIEW

Section 237. Utilization Review Requirements for Hospitals and Skilled Nursing Homes Under Medicaid and Under Maternal and Child Health Program

Effective January 1973, Section 237 of H.R.–1 requires that hospitals and skilled nursing homes participating in Titles V (Maternal and Child Health) and XIX (Medicaid) use the same utilization review committees and procedures now required under Title XVIII (Medicare). In effect, this extends to Medicaid and Maternal and Child Health programs all the Medicare requirements for certification by a physician of the necessity for care, for recertification by a physician of the necessity for continued care beyond a certain time limit, and for a utilization and review committee to monitor the hospital's medical performance. Unless these requirements are met, claims for Medicaid or Maternal and Child Health reimbursement for services rendered will be disallowed.

Clearly, this provision requires the Corporation to strengthen each Corporation hospital's utilization review activities and the claims review procedures used by its patients account office. Corporation hospitals will be forced to cope with the extension of utilization and review requirements from 10 to 15 percent of the Corporation's patient population to approximately 70 percent of the Corporation's patient population (those covered by Medicare and/or Medicaid). It becomes imperative that measures be taken to allow the utilization and review committees and procedures at each Corporation hospital to cope with this new/expanded workload.

Apart from making every effort to facilitate the administrative procedures which support utilization and review activities, Corporation physicians must fulfill their responsibilities to complete certifications and recertifications as to the necessity for hospitalization and the extent of post-hospital care requirements.

A number of steps are being explored by the Corporation concurrent with the effective date of this section, January 1973. First, the Corporation is attempting to obtain any diagnostic length of stay profiles specifying appropriate lengths of stay for various medical conditions for those diagnoses which are not normally found in Medicare patients (the Corporation has such a profile for Medicare purposes only). These, then, could serve as guidelines for the hospital's utilization and review activities and as indicators of when recertifications should be done. Second, the Corporation must request from the State an easement on the immediate implementation of this provision, pending the development of a standardized system for the Corporation as a whole. The Corporation can argue for such an easement on the grounds that the majority of its patients are covered by Medicaid and that to establish an effective utilization and review plan for this large a group requires the hiring and training of clerical personnel, the employment of additional physicians, the revision and development of new forms and procedures, the institution of new case controls and the acquisition of additional space and equipment to carry out these functions.

Section 207. Incentives for States to Establish Effective Utilization Review Procedures Under Medicaid

Section 207 of H.R.–1 requires that states participating in the Medical Assistance Program have an effective utilization review program for the primary services covered under Medicaid. Failure by a state to have an effective utilization and

review program will result in a one-third reduction of Federal Medical Assistance funds in support of the Medicaid program for each stay over 60 days in a general hospital, tuberculosis hospital, skilled nursing facility or intermediate care facility, and a one-third reduction for each inpatient mental hospital stay.

The State is responsible for setting up independent professional review teams which will be responsible for sampling on an annual basis the cases at all institutions. This program of review must evaluate the necessity for admission and the continued stay of patients. Included in this review must be evidence that a physician certified the need for care, that recertifications (with supporting material) were furnished appropriately (at least every 60 days), and that all patient services were furnished under a plan established, periodically reviewed and evaluated by a physician.

The Secretary of Health, Education, and Welfare will verify the effectiveness of the State's utilization review activities by conducting sample on-site surveys of private and public institutions, the results of which will become a matter of public record.

These two utilization review oriented sections (237 and 207)of H.R. 1 have serious fiscal consequences for the Health and Hospitals Corporation. Losses to the Corporation could exceed substantially $20 million per year or more (*not* to be added to the possible losses due to PSRO's). It should be noted that much of such disallowance would be discriminatory in nature in that a large proportion of the Corporation's long stay cases are disposition problems awaiting the availability of places in alternative, more appropriate treatment facilities or awaiting completion of extensive procedural requirements for placement in such institutions. Therefore, given that such patients often have no realistic alternative to the Corporation hospital other than the street and perhaps death, it is unfair to severely penalize the Corporation for its relative humanitarianism.

For information purposes only, it is crudely estimated that cost of operating the Corporation's claims processing system under the enlarged utilization review requirements will be $19.2 million per year, as opposed to the present cost of $6.4 million for claims processing: an additional cost of $12.8 million.

EXPANSION OF ELIGIBILITY PROVISIONS

Section 201. Medicare Coverage for the Disabled

Health insurance protection under the Social Security Act has been extended to include individuals under 65 years of age who have been entitled to Social Security disability benefits for at least 24 months. These disability beneficiaries are now covered under H.R. 1 for hospital and related post-hospital services under Part 4 of the Medicare Program. They include:

Disabled workers at any age;

Disabled widows and disabled dependent widowers between 50 and 65 years of age;

Women aged 50 or older entitled to mother's benefits who, for 24 months prior to the first month they would have been entitled to Medicare protection had met all the requirements for disability benefits except for actual filing of a disability claim;

Childhood disability beneficiaries aged 18 and over who receive Social Security benefits because of disability incurred prior to reaching age 22; and

Disabled qualified railroad retirement annuitants who have received Social Security benefits for at least 24 consecutive months.

An individual may be considered disabled if he or she is unable to engage in any substantial activity by reason of a medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can can be expected to last for a continuous period of not less than 12 months. A period of disability may be established for a worker who was disabled for a continuous period of at least six full calendar months before reaching age 65, but a disabled worker is not eligible for monthly cash benefits until the six-month waiting period has been completed. The extension of Medicare eligiblity to include the disabled under Part A of the Medicare program is effective in late July 1973 or in the 25th consecutive month of entitlement to Social Security disability benefits. For the purposes of compliance with this section, a disabled individual must wait the necessary six months for disability entitlement and then an additional 24 months before hospital insurance coverage begins. Medicare benefits will terminate the month following notice of termination of disability benefits. An estimated 1.7 million (nation-wide) disabled beneficiaries would be eligible initially.

A detailed financial analysis of this provision is not currently possible given the paucity of Social Security data. However, one can be fairly certain that this

new group of Medicare recipients will represent a loss in revenue since most of the patients involved are currently enrolled either in the Medicaid program or (less likely) in a commercial insurance plan. Given Medicare's legal billing priority, the Corporation will be required to claim for services rendered to such patients from Medicare, with a resulting loss of about $20 per diem due to the lower than Medicaid per diem rate. In addition, the costs of processing Medicaid claims are substantially higher than those of processing Medicaid claims and the probability of collection of processed bills is lower for Medicare than for Medicaid.

Section 202. Hospital Insurance for the Uninsured

Coverage under Part A of the Medicare program is now available to individuals formerly considered ineligible under a provision entitled "Special Transitional Provisions." Such coverage is provided for a monthly premium charge of $33.00. This premium can be expected to rise in later years as hospital costs increase. States and public organizations, through agreements with the Secretary of HEW, are permitted to purchase this Part A coverage on a group basis for their employees.

Individuals who have not earned a specified number of quarters of coverage in employment or self-employment under the Social Security program now have the opportunity to purchase hospital insurance from such program. These people may enroll for hospital coverage on a voluntary basis but if they do, enrollment for supplementary medical insurance is mandatory. Moreover, termination of Part B coverage by individuals made eligible by this provision will result in simultaneous termination of hospital insurance benefits.

The impact of this section is expected to be minimal given the relative unattractiveness of the cost of such coverage ($400 per year per person).

Section 206. Automatic Enrollment for Supplementary Medical Insurance

Effective 1 July 1973, H.R.–1 provides (except for residents of Puerto Rico and foreign countries) for automatic enrollment under Part B for the elderly and the disabled as they become eligible for Part A hospital insurance coverage. Any individual may decline enrollemnt in Part B only if he complies with a specific procedure to be established by the Social Security Administration.

Since Part B covers all ancillary services, this has a beneficial effect in additional third party coverage for those people who are not eligible for Medicaid. This could also reduce inhospital utilization since many services which up to now have been given on an inpatient basis will be covered on an outpatient basis. In addition, this should place greater emphasis on preventive medicine.

To the extent that this provision adds third party coverage to patients without alternate forms of such coverage, the Corporation will benefit in additional revenue. To the extent that such coverage replaces Medicaid coverage, the Corporation will lose revenue from the lower Medicare ambulatory care visit rates and from the need to bill Medicare coinsurance and deductible disallowances to Medicaid, a complex administrative process that is not always successful. However, Part B also covers reimbursement for physician services for inpatient stays and, therefore, such additional coverage for Medicare coverage will result in additional Corporation revenue. Overall, this provision is essentially a break-even or slightly positive fiscal benefit to the Corporation.

Section 209. Protection Against Loss of Medicaid Coverage Because of Increased Earnings

An individual or member of a family eligible for cash Public Assistance and Medicaid who would otherwise lose eligibility for Medicaid as a result of increased earnings from employment would be continued on Medicaid for a period of four months from the date when Medicaid eligibility would otherwise terminate. Effective date for this provision is 1 January 1974.

This provision should increase Corporation revenues very slightly since some of the uninsured people who currently utilize our facilities will now have coverage for a limited time period.

Section 249–F. Medicaid Eligibility for Certain Persons Receiving the 20 Percent Increase in Social Security Benefits

Effective 30 October 1972, this section provides that for the purposes of determining Medicaid eligibility, any individual who was eligible for receiving Social Security benefits in August 1972 and was eligible for or was receiving a cash grant under a State plan in a Federal related category (i.e. Aid to the Aged, Aid to the Disabled, Aid to the Blind, and Aid to Families with Dependent Children) will not be made ineligible for Medicaid solely on the basis of the 20 percent increase in Social Security benefits through October 1974.

Individuals (estimated at 100,000 in New York City) will retain Medicaid eligibility until October 1974 even if they are no longer entitled to cash public assistance. Given that such patients might not otherwise be able to pay for their medical care, continued Medicaid coverage will be of fiscal advantage to the Corporation (which would otherwise be expected to bear such costs) but will not increase current Medicaid revenue.

Section 255. Coverage Prior to Application for Medical Assistance

Effective 1 July 1973, this amendment provides for Medicaid coverage for three months prior to actual application, providing that the patient was eligible at the time care and services were furnished.

This section simply enacts into Federal law the current practices of the New York State Medicaid program.

EXPANSION OF SERVICE BENEFITS

For the sake of brevity, the following is a listing of some of the additional benefits allowed under Medicare and Medicaid as a result of the passage of H.R. 1. It should be remembered that although certain benefits are newly covered under the Medicaid program, and thus eligible for the Federal portion of reimbursement, it is still left to the State to determine if such service will be offered as a benefit under the State's Medicaid Program.

Section 299B.—This section authorizes the coverage of inpatient care in mental institutions for those Medicaid eligible individuals under 21 years of age.

Section 212.—Medicaid coverage is expanded to include services provided by optometrists.

Section 251.—Medicare coverage, under Part B, is expanded to include physical therapy services provided in a physical therapist's office or in a patient's home.

Section 252.—Medicare coverage, under Part B, is expanded to include those supplies related to colostomies.

Section 256.—Medicare coverage, under Part A, is expanded to include inpatient hospital service for dental procedures, based on a certification of necessity for admission filed by the patient's dentist and by a physician.

Section 264.—Medicare coverage is expanded to include those services provided by optometrists in furnishing prosthetic lenses.

Section 277.—This section allows the State to provide consultant services to skilled Nursing Facilities in order to bring the facilities into compliance with Medicare requirements. The cost to the State is reimbursable under the Medicare program.

Section 283.—Medicare coverage is expanded to include speech pathology services in concert with outpatient physical therapy services.

Section 299E.—This section authorizes 90 percent Federal funding for the cost of family planning services under Medicaid. Unless a State informs the adults in AFDC families of the availability of family planning services and arranges for the provision of such services, the Federal government will reduce its share of Aid to Families with Dependent Children by 1 percent beginning Fiscal Year 1974.

Section 299I.—This section extends Medicare coverage, under Parts A and B, to those individuals considered disabled (and who receive monthly Social Security benefits) requiring chronic hemodialysis or renal transplantation for chronic renal disease. Coverage begins the third month after the beginning of dialysis treatment and ends twelve months after a transplant or at the conclusion of treatment. Since most of the Corporation's dialysis patients (under 65) are currently Medicaid-eligible and since Medicaid reimburses the Corporation at its full inpatient rate for dialysis treatment rendered these patients, the Corporation stands to lose a substantial amount of revenue associated with this treatment if the Medicare program only reimburses for such service on an outpatient basis or at the Medicare inpatient rate (which is approximately $20 less per diem than the Medicaid rate).

COST-SHARING BY THE RECIPIENT: PREMIUM, DEDUCTIBLE AND COINSURANCE PROVISIONS

Section 208. Premium

H.R.–1 requires states which provide health services under Medicaid to medically indigent (non-cash Public Assistance recipients) individuals and families to levy monthly premium charges on such individuals and families. The size of the monthly premium will be determined by the Department of Health, Education

and Welfare and will be graduated by recipient income, probably as a fixed percentage of annual income for affected individuals and families. Not yet fully clear at this time is the method of collection of such premium and the consequences of failure on the part of the medically indigent to pay such premium; resolution of these issues is of great importance to the Corporation, as described in the following paragraphs.

In New York City, approximately 1.5 million people currently are enrolled in Medicaid, of whom 1.2 million people are cash Public Assistance (PA) cases and 0.3 million are medically indigent (MA) cases. The differences in income level between PA and MA cases is effectively meaningless; neither can afford more than minimal health care costs. Thus, if—as seems likely—the relevant Federal and State regulations are finally written to require MA cases to personally submit premium payment checks monthly or quarterly (the amounts cannot be deducted from welfare payments since there are no such payments for MA cases), the overwhelming probability is that nearly all such payments will *not* be made. H.R.–1 allows a 90-day grace period for continued Medicaid enrollment after failure to pay the required premium with an additional 90-day grace period for cases where the Secretary of HEW finds good cause for such non-payment. After such grace period is expired, however, the individual must be dropped from the Medicaid rolls and cannot be reinstated until he reapplies and pays his required premium.

As stated, it is up to the State to specify which organization will be responsible for premium collection, but it will probably be either the State or City Department of Social Services. The reality of the situation, however, is that the City or Health and Hospitals Corporation will end up paying all or most of such premium charges simply because it is in their (and no one else's) interest to do so. To understand how this is true, assume a former MA individual is dropped from the Medicaid rolls for premium non-payment. Upon requiring medical care, such individual must of necessity come to a Corporation facility. The cost of such care now must be borne by 100 percent City Tax Levy (it being doubtful that the patient will be able to contribute a significant amount of his bill). If such patient were still MA-enrolled, then typically a major portion (50 to 75 percent depending on the service) of such cost would be borne by State and Federal funds. Thus, through imposition of the premium and termination of Medicaid benefits for non-payment, the State and Federal governments reduce program costs and the City and Corporation incur an even greater fiscal burden for provision of health care to the medically indigent.

Assuming that MA and PA cases have identical health needs and receive identical health services, the Corporation could lose (and have to replace with City Tax Levy) up to 20 percent of its current State and Federal Medicaid dollars, for a maximum unpaid total of almost $60.0 million (in Fiscal Year 1973 terms) *plus* be forced to pick up the full health costs of any MA case now treated in the voluntary health system in New York City for whom such system may no longer continue treatment. The dollar value of the latter is unknown but could be at least another $60.0 million.

Given the above prospect, it is fiscally advantageous and virtually inevitable that the City pay for *all* premium charges for *all* New York City MA cases. If such premium is $5 per month per enrollee, the cost is 300,000 × $60 = $18 million, far less than the above losses in City Tax Levy. Perhaps the voluntary hospital system could be persuaded to share in such cost since it really can't afford to lose the "business" and funding provided by MA cases. Administratively, such City payment would be most easily made by the City Department of Social Services which maintains the MA Master File and which, in turn, could be expected to bill the Corporation.

In conclusion, the almost inevitable result of the imposition of monthly premium charges for MA cases will be its exposure as a means of limiting health care for the medically indigent and the assumption on the part of local government of greater fiscal responsibility for such care. The only rational response for the City and Corporation is to pay for such premium charges and to seek partial reimbursement from the local voluntary hospitals (through the Voluntary Hospital Association) and from the State through the Legislature. This provision is effective 1 January 1973.

Section 208. Coinsurance and Deductibles

H.R. 1 also allows states, at their option, to require payment by MA cases of nominal deductibles and coinsurance (which would not have to vary by level of income) and to require payment by PA cases of nominal deductibles and co-

insurance for non-mandatory services required under Federal law. The six mandatory services are inpatient hospital services, specified outpatient hospital services, other X-ray and laboratory services, skilled nursing home services, physician services, and home health services; non-mandatory services include prescribed drugs, dental care, prosthetics, hearing aids, etc. The Federal government will probably define nominal in terms of a maximum percentage of cost or a maxlmum dollar charge.

Any implementation by New York State of these coinsurance and deductible providions for Medicaid is likely to result in a scenario similar to that of the monthly premium charge: namely, imposition of greater costs on those *least* able to afford it with the result that they are either forced to forego needed medical care or the Corporation (City) will have to fully fund such charges, as has already been the case in the instance of the Corporation's assumption for Medicare patients of the Part B deductible and coinsurance.

The only difference between the City's assumption of premium versus the coinsurance/deductible costs is that in the latter care the Corporation will directly incur the cost since the State will automatically deduct such cost from the Corporation's Medicaid claims and let the *Corporation* collect what it can from the patient. Since the hospital effectively shares in or covers the patient's increased fiscal burden regardless of choice, there is no termination of patients from the Medicaid rolls for non-payment of a deductible or coinsurance. The State, however, may not institute the administratively complex deductible provision since the charge can only be nominal *and* since it will require State maintenance of a continually updated, sophisticated and expensive "master file of deductible payments."

The cost to the Corporation of this provision depends totally on State action and the Corporation should attempt to ensure that such action is "no action." This provision is effective 1 January 1973.

Section 208. Medicare Annual Deductible

Effective 1 January 1973, the annual Medicate Part B deductible charge is increased from $50 to $60. The Corporation currently assumes the major portion of such costs for its Medicare patients. Thus, the cost to the Corporation of this provision is $.20×$0.600 million (current Corporation Part B deductible "subsidy")=$0.120 million per year. No Corporation appeal is possible on this provision except to the Department of Health, Education and Welfare within 90 days issuance of formal regulations.

SKILLED NURSING FACILITIES

Section 246. Uniform Standards for Skilled Nursing Facilities Under Medicare and Medicaid

This provision is to establish a single definition and set of standards for extended care facilities under Medicare and skilled nursing homes under Medicaid, both of which, effective July 1973, are to be called skilled nursing facilities. Unfortunately, detailed presentation of the criteria for being termed skilled nursing facility are not yet available, but it is known that such criteria will not mandate a minimum number of nursing hours per patient. Moreover, the definition will encompass as a skilled nursing facility an aggregation of unskilled services which require overseeing of skilled personnel.

A second type of institution also to be defined by H.R. 1 is an intermediate care facility. Such facilities are expected to provide less intensive care than skilled nursing facilities and will, consequently, be reimbursed at a lower per diem rate. Tentative observations as to what the intermediate care definition will encompass include therapeutic half-way houses and other similar facilities that provide a care greater than room and board. Note also that a skilled nursing facility and an intermediate care facility may exist under the same roof. Other provisions of H.R. 1 allow use of special consultative services for Medicare patients in a skilled nursing facility, subject to approval by the Secretary of HEW and no longer require as a condition of Medicare participation that medical social services be provided.

The potential impact of the above is possible reclassification of the extended care wings of the Corporation's three long-term care hospitals—Sea View, Coler and Goldwater Hospitals—and the extended care wards of those Corporation general care hospitals with such service. The Corporation would want all such areas classified as skilled nursing facilities in order to realize the higher reimbursement rate. What this will require depends, of course, on the specific definition requirements which are not yet available.

Section 249–A. Medicaid Certification and Approval of Skilled Nursing Facilities

Effective 30 October 1972, this provision requires skilled nursing facilities participating in both the Medicare and Medicaid programs to be certified by the Secretary of HEW as satisfying specified standards. The Secretary will make such determinations principally on the basis of appropriate state health agency evaluations of skilled nursing facilities. Certification agreements with such facilities will be for a period of no more than 12 months, but may be extended for an additional two months in certain instances. Agreements accepted by the Secretary before 30 October 1972 are deemed to be for a specified term ending 31 December 1973. This provision of the law allows for annual surveys of skilled nursing facilities or extended care facilities. Depending upon the evaluation criteria used by the State health agency it may well be that our extended care facilities will not be found to meet the requirements of a skilled nursing facility.

Section 228. Advanced Approval of Extended Care in Home Health Coverage

This section authorizes the Secretary of HEW to establish, by diagnosis, specific periods of time after general care hospitalization during which a patient will be presumed to require extended care services. The physician must certify the need for such care and submit to the extended care facility, in advance of admission, a plan for carrying out the required services. Similar provisions apply to post-hospital home health services.

This provision means that for all admissions to extended care facilities after 1 January 1973, where the patient has been discharged from a general care facility, the patient's physician must certify to the need for extended care and submit to the extended care facility a treatment plan. To ensure Medicare reimbursement it is imperative that the institutional personnel comply with this procedure. Additionally, every time a change in a patient's condition is such as to significantly alter the level of care required, the institution is obligated to notify the Social Security Administration. Clearly, it would be in the Corporation's interest to create another diagnostic profile to be used for extended care stays. Additionally, we should seek official approval of this profile rather than be required to utilize the diagnostic profile developed by HEW which does not give sufficient consideration to the characteristics of our patients requiring extended care.

Section 248. Modification of Medicare's 14–Day Transfer Requirement for Extended Care Benefits

The Medicare extended care requirement that a patient's transfer to an extended care facility take place within 14 days of discharge from a hospital is modified to permit longer intervals for patients whose conditions do not permit provision of skilled services within 14 days. An extension not to exceed two weeks beyond the 14 days would also be authorized in those instances where an admission to an extended care facility is prevented because of the non-availability of appropriate bed space in facilities ordinarily utilized by patients in a specific geographic area.

This provision is beneficial. It allows the provider to claim covered days even though the previous 14-day limitation has been exceeded. The provider must be able to substantiate delays for transfers due to medical reasons or lack of available bed space. Even with this benign modification in the transfer requirement, the length of time elapsed must be monitored so that the new time limits will not be exceeded. This provision is effective 30 October 1972.

COST CONTROL PROVISIONS

Section 221. Limitation on Federal Participation for Capital Expenditures

This provision would allow the Secretary of HEW to preclude Medicare or Medicaid payments for certain disapproved capital expenditures which are specifically determined to be inconsistent with state or local health facility plans. Precluded payment is defined as non-reimbursement of corresponding depreciation and interest costs; the section is effective 1 January 1973. This section has no impact on the Corporation as its capital plans are submitted for approval to the Health and Hospitals Planning Council of Southern New York.

Section 225. Limitation of Payments to Skilled Nursing Facilities and Intermediate Care Facilities Under Medicaid

Effective 1 January 1973, Federal financial participation in Medicare or Medicaid reimbursement for skilled nursing facility care and intermediate care per diem costs will not be made to the extent such costs exceed 105 percent of prior

year levels of payment, *except* for those costs attributable to any additional required services. Increased payment resulting from increases in the Federal minimum wage or other new Federal loans are also exempted from this restriction.

Given that inflationary factors on wages and supplies have been averaging 8 percent recently and that the Corporation has no control over such factors, the Corporation will be penalized by this provision to the extent that rate increases will not fully cover actual costs if such costs increase by greater than 5 percent annually. While the State could participate in funding such "excess" costs it is likely that it will choose not to do so. The resultant expected loss in State and Federal funds could be up to $2 million per year.

Section 224. Limits on Prevailing Physician Charge Levels

For Medicare reimbursement purposes, recognized "reasonable" charges are only those which fall within the 75th percentile of the customary charge made for similar services in the same locality. Such charges include physician fees; with respect to reasonable charges for medical supplies and equipment, reasonable charges are those for which supplies of similar quality are widely and consistently available in the locality. While somewhat vague, this provision, which is effective 1 January 1973, will have no impact on the Corporation in the immediate future. It will, however, adversely affect many of the City's voluntary hospitals.

Sections 223 through 233. Hospital Costs

H.R.–1 allows the Secretary of Health, Education and Welfare to establish limits on overall direct or indirect costs which will be recognized as reasonable for comparable services in comparable facilities in an area for Medicare purposes. He may also establish maximum acceptable costs in such facilities with respect to items or groups of services such as food costs.

The bill also authorizes states with the advance approval of the Secretary of HEW to develop their own methods and standards for reimbursement of the reasonable costs of inpatient services. Reimbursement by the states would in no case exceed reasonable cost reinbursement as provided under Medicare.

Theoretically, the above provides a very effective control measure as it essentially provides item-by-item as well as total cost control authority. However, similar provisions have been legal under Medicaid for years and have not been used. While the Corporation could have some of its item costs judged unreasonable, the major focus of attention of these provisions, if enforced, would be on the volunatry hospital system.

Section 229. Authority of Secretary of Health, Education and Welfare to Terminate Payments to Suppliers of Services

Effective 30 October 1972, the Secretary of HEW has the authority to terminate or suspend payments under the Medicare program for services rendered by any supplier of health or medical services found guilty of program abuses. Situations for which termination of payment will be made include overcharging; furnishing excessive, inferior or harmful services; or making a false statement to obtain payment. Also, there will be no Federal financial participation in any expenditure under the Medicaid and Maternal and Child Health programs by the State with respect to services furnished by suppliers to whom the Secretary would not make Medicare payments under this provision of the law. Program review teams will be established to furnish professional advice to the Secretary in carrying out this authority. This should have no immediate effect on the Corporation.

STATE MEDICAID FUNDING RESTRICTIONS PROVISIONS

Section 230. Elimination of Requirement that States Move Toward Comprehensive Medicaid Programs

Section 230 immediately repeals Section 1903(e) of Title XIX and Section 2(b) of Public Law 91–56 which required each state to show that it was making efforts toward broadening the scope of Medicaid services offered and liberalizing eligibility requirements for its medically indigent. Failure to do so previously could have resulted in the Secretary of HEW halting Federal Medicaid payments.

Until recent cutbacks, New York State was one of the most progressive states in adhering to Section 1903(e); now it has no pressure to continue its former liberality, which will certainly deprive many truly medically indigent people of needed health care services or force municipalities to continue to finance such health care, a large and difficult fiscal burden. Moreover, the following Section 231 allows the State to essentially reverse past progress, thereby seriously reducing current health services or worsening the current fiscal burdens of the municipalities.

Since implementation of this section does not require state regulation or legislative change, pressure to continue broadening the scope of Medicaid covered services and people can be affected only through specific State legislation and/or expansion of the State Department of Health's Medicaid coverage provisions and the State's funding thereof.

Section 231. State Medicaid Maintenance of Effort

This section immediately repeals Section 1902(d) of Title XIX which prevented a state from reducing its total Medicaid expenditures (in reality the State share) from one year to another.

This is a potentially devastating section which allows the State to virtually eliminate Medicaid payment for all current medically indigent cases and/or all optional Medicaid services. The 50 to 75 percent cost support, depending on the particular services of such care rendered to such patients which is currently borne by Federal and State funds would then have to be borne by the patient, the voluntary/proprietary provider of services, or, most likely, the City through the Corporation hospitals.

The State, to some unknown extent, will probably quickly utilize such provision. Recently, before H.R. 1 passage, the State attempted to reduce by half the number of enrolled MA cases but lost the resulting court case. Such reduction would *not* have reduced State Medicaid expenditures beyond the previous year. Thus, the new H.R. 1 provision gives the State even greater program cost reduction flexibility.

In all likelihood, the State will only partially cut the MA case rolls and eliminate only certain optional services (such as abortions). Almost regardless of the extent of any such reduction, however, the results would be fiscally disastrous to the Corporation. Thus, every effort should be made to introduce and pass in the State legislature a bill similar to the repealed section 1902(d) of Title XIX which would simply require annual maintenance of effort by the State with regard to State Medicaid expenditures. Appropriate inflationary increases should be included in such calculation. This would effectively limit or prevent potential State reduction in its Medicaid program. Otherwise, the interested parties would have to resist *individually* every State attempt at program reduction through curtailment of service or individual eligibility, such attempts probably having to be made in the State Legislature.

Section 284. Elimination of Maintenance of Effort by States for Geriatric Mental Health Hospitalization

This section immediately repeals Section 1903(b) of Title XIX which required States to spend at least as much for care of individuals aged 65 or over in mental hospitals as in Fiscal Year 1965. This provision has been made meaningless by inflation and, furthermore, the State rather than the City generally pays for such care. This section has no foreseeable effect on the Corporation.

HEALTH MAINTENANCE ORGANIZATIONS

Section 226. Payments to Health Maintenance Organizations

Section 226 of H.R. 1 authorizes the Medicare program to make a single combined Part A and B payment, on a capitation basis, to a Health Maintenance Organization (HMO) for Medicare enrollees. The HMO would, in turn, agree to provide all the services and benefits covered under Medicare Part A and B to an enrolled population, not more than one-half of which are Medicare beneficiaries who voluntarily choose this arrangement. The payment of a capitation rate may not exceed present Part A and B per capita costs in a given geographic area and would be based on the organization's annual operating budget and enrollment forecast. If after the contract year, the HMO experienced savings on the adjusted average per capita cost, up to 20 percent of such savings would be apportioned equally between the organization and the Medicare Trust Funds. Any savings in excess of 20 percent would revert entirely to the Trust Funds.

The advantages of this HMO concept are that it offers the provider an incentive to contain his costs and to provide care effectively and efficiently, and it allows the provider to rely on a stable source of revenue. Since the HMO is reimbursed on the basis of a per capita rate, it is in its own interests to ensure that the least expensive alternative mode of treatment is employed for each patient and yet ensure that a sufficient standard of quality of care is delivered so as not to jeopardize the medical condition of the patient for which the HMO is responsible (and for which State and local groups may act as monitoring bodies). In addition, with a guaranteed amount of income as is the case with an annual per capita rate,

the HMO is much more able to constructively plan and budget accordingly for its annual operating costs.

There is, however, one flaw in this section of H.R. 1 dealing with HMO's. Nowhere is there mention of sufficient financial and economic incentives for the *development* of HMO's. While an HMO may clearly be preferable as a means of organizing health care services, there must be a national mechanism established to provide the financial incentives necessary for organizations to undertake the high developmental costs associated with creating an HMO.

In many ways, the Corporation is an ideal organization to fulfill the objectives of an HMO. It encompasses a wide geographical region, has a varied patient population, has become the "primary physician" for many citizens of New York City, and has the capability to provide the entire range of primary and specialty services required of any HMO. Unfortunately, it currently appears useless for the Corporation to consider moving in the direction of reorganizing into HMO's unless the State *Medicaid* program would also allow payment to be made on a similar capitation basis for Medicaid recipients. It would also appear premature to consider establishing HMO's until sufficient funding is available to (1) undertake the massive planning effort required for such reorganization and (2) to cover start-up costs. And finally, the Corporation would face a major problem in regard to enrolling a population group in any HMO it was to create in that the population now served by the Corporation in many of its facilities is extremely mobile.

Section 240. Relationship Between Medicaid and Comprehensive Health Programs

This section provides a *potential* solution to and of the problems mentioned above: initiation of parallel State legislation with regard to Medicaid prepayment on a capitation basis to an HMO. This section allows such payment provided the capitation rate is not higher than the capitation Medicaid expenditures in the same general area, provided the health services available are in excess of the State Medicaid plan, and provided that enrollment is voluntary. The Secretary of HEW must approve any such contracts.

DEMONSTRATION FUNDS

Section 222. Creation of Demonstrations and Reports Project; Prospective Reimbursement; Extended Care; Intermediate Care and Homemaker Services; Ambulatory Surgical Centers; Physicians Assistants; Performance Incentive Contracts

Effective 30 October 1972 this section authorizes the Secretary of HEW to develop experiments and demonstration projects designed to test various me thods of reimbursement to providers of services on a prospective basis under Medicare/Medicaid and Maternal and Child Health programs. In addition, the Secretary is authorized to conduct experiments with methods of payments designed to increase efficiency; with performance incentives for intermediaries and carriers; with reimbursement implications for paying of services rendered by physicians' assistants; with the use of intermediate care and homemaker services by beneficiaries who either are ready for discharge from a hospital or unable to maintain themselves at home without assistance; with programs designed to improve the rehabilitation of patients at long-term health care facilities; and to determine whether services of clinical psychologists might be made more generally available to persons under Medicare and Medicaid.

It is certainly in the interest of the Corporation to take advantage of this opportunity to develop experimental reimbursement pilot programs which may resolve or relieve some of the problems currently being experienced in securing reimbursement. Since, however, the Corporation does not receive reimbursement directly from the Medicare and Medicaid programs, and still must rely on the funds being channeled through the City of New York, it may be premature to explore the advantages of various types of prospective reimbursement until the issue of direct payment is resolved.

Section 235. Payments to States Under Medicaid for Installations and Operation of Claims Processing and Information Retrieval Systems

Effective 1 July 1971 this section provides payments to states for that portion of costs attributable to the design, development and installation of information retrieval systems and mechanized claims processing systems if they are deemed likely to provide efficient, economical, and effective claims processing compatibility with the system utilized in the administration of Title XVIII. Payments will also be made for the cost of operating such systems. Federal reimbursement will be as follows:

90 percent of the cost of design, development or installation of a mechanized claims processing and information retrieval system;

90 percent of the cost of the design, development or installation of cost determination systems for State-owned general hospitals; and

75 percent of the costs associated with the operation of the systems.

While this section authorizes Federal payment to *states* to develop, implement and operate various information retrieval and claims processing systems, the Corporation should explore with the Secretary of HEW the possibility of directly contracting with the Federal government to provide such capability. Based on the fact that the Corporation is of such significant magnitude, it would seem possible to convince the Federal government that such support of a Corporation information system would be a positive investment of Federal money. Since the Corporation has recently installed a system designed to accomplish the objectives of this section—the Case Management System—all steps should be taken to explore the possibility of Federal support for the operation of this system.

PUBLIC DISCLOSURE PROVISIONS

Section 249–C. Disclosure of Information Concerning the Performance of Carriers, Intermediaries, State Agencies, and Providers of Services Under Medicare and Medicaid

Section 249–C of H.R.–1 provides that the Secretary of Health, Education and Welfare will, on a regular basis, make public the following types of evaluations and reports with respect to the Medicare and Medicaid programs:

Reviews of individual contractor performances and other evaluations of the performance of carriers, intermediaries and State agencies;

Comparative evaluations of the performance of such contractors—either on overall performance or selected contractor operations; and

Program validation survey reports and other evaluations of the performance of the providers of services.

Before any report is issued to the public, the Secretary will provide a reasonable opportunity for the contractor or the provider of service to offer comments.

This section, in essence, allows HEW to publicly issue official audit reports on the performance of Medicare and Medicaid agents and providers of service. As a public benefit corporation, the Health and Hospitals Corporation has had considerable experience with a variety of outside agencies auditing all areas of its operation; while this, therefore, may not be a new experience, the Coporation must be concerned about the deficiencies that may be uncovered by survey reports and performance evaluations in regard to its handling of Medicare and Medicaid cases.

Section 229–D. Public Disclosure of Information Concerning Survey Reports of an Institution

Section 299–D requires the Secretary of HEW to make public (readily and generally available) the pertinent findings of any survey report completed by a state or local agency on an institution's compliance with staffing, fire safety, and sanitation standards as required under the Social Security Act. Again, the Corporation already has been subject to public scrutiny in these areas.

The key aspect of the above public disclosure provisions is not what they require but rather what they do not require. Most importantly, they do not require public disclosure or disclosure to City health agencies of summary financial data of individual New York City hospitals submitted to Medicare/Medicaid for reimbursement rate determination, *despite* the annual contribution of hundreds of millions of City Tax Levy dollars in support of such rates. The Corporation's cost information as represented by its cost stepdowns is publicly available. Within the last year, a class suit for union and consumer groups has been filed in New York State requiring public disclosure by all hospitals of such fiscal information. The City of New York and the Coporation should join in such request as a necessary condition for responsible as well as reasonable hospital cost control.

MISCELLANEOUS PROVISIONS

The following summarizes provisions not expected at present to have immediate major effect on the Corporation but still of significant current or potential importance.

Effective January 1973, the same State health agency (the State Department of Health) must certify facilities for participation under both Medicare and Medicaid.

Various penalties (fines and imprisonment) are imposed for falsification of information, bribery, concealment of information, etc. regarding benefit payments and rate determinations.

A Federal Provider Reimbursement Board is established (effective 30 June 1973) to hear cases involving an issue of $10,000 or more, with such issues including failure of the fiscal intermediary to make accurate or timely cost determinations. *No* powers are specified for such Board.

The Secretary of HEW can now promulgate health and safety standards for hospitals without being restricted to Joint Commission on Accreditation of Hospitals standards.

Under Title XIX, for purposes of mandatory provision of physician services, such services must be rendered by a "duly licensed" doctor of medicine or osteopathy. The meaning of "duly licensed" is left to State discretion.

Effective January 1973, Part B Medicare coinsurance payment is not required for home health services. The Corporation, however, presently does not bill Medicare at all for such services.

Mr. CARTER. How would you like to see medicare and medicaid changed, in what way? How would it be most helpful to the people and to you as administrator—I guess that is your position.

Dr. ENGLISH. Yes. Well, Mr. Carter, our corporation is now close to a $900 million operation, with a construction budget in excess of $1 billion. It is a major corporation in the United States and the largest health care organization of its kind in this country. Now when I take a look at the fact that we have to have literally thousands of people involved in some of the worst paperwork mills that I have seen in all of my experience at a cost of some $20 million a year, trying to satisfy the paperwork requirements of medicare, and medicaid, which are now different than the paperwork requirements of Blue Cross and Blue Shield and union health insurance plans and all the rest, all I would say to you is that as we move toward some stable financing of health care in this country and as we move in the direction of a national health insurance program, as an administrator the first thing that I would suggest to you is that we must simplify this incredible paperwork process. Our major effort has been involved in trying to cope in an organization of our size with the demands which that process imposes upon us. So that is No. 1.

No. 2, that decisions about cutbacks in programs of medicaid ought to have the jurisdiction or the review not just of welfare people basically at the Federal and State levels, but there ought to be health policy input into those decisions. At the State level in New York City that process is totally inadequate. The commissioner of health has very little to say about cutbacks that are largely coming out of the welfare administration in the State of New York. And as we look to the Federal Government and to the leadership and assistance that Dr. Edwards ought to be able to give to us in that kind of a problem it is very clear that his jurisdiction in this area is most questionable, even though it is clearly going to be a health care crisis that this causes in New York. So what I would like to see is simplification of the process and where the health leadership of this Government has some say-so and some control and some real policy input over decisions that are made by people that know nothing about health, that have little priority and concern for health, and really that the issues that those decisions confront us with can somehow be looked at by committees such as this which are steeped and well grounded in substantive health care concerns.

Mr. CARTER. What cutbacks have you had in medicaid in New York City? What percentage does the Federal Government pay of the medicaid bill?

Dr. ENGLISH. Well, what we have seen happen is the eligibility for medicaid reduced so that many fewer people today in New York City are covered by medicaid. We see the medicaid program covering fewer and fewer things, and we now see a situation where purely on economic grounds the paperwork process is going to be magnified to the point where it makes it much more difficult for us to get those revenues for services we are providing.

As one example of this, the 4-page medicaid form that we now have to get filled out for patients of the kind we take care of who very often don't have families, who sometimes don't speak English, that 4-page form is now going to become a 10-page form. And if I might submit that to the committee then I think you would find the reason why it is going from 4 pages to 10 pages is not because you really need that much more information to insure that an insurance program passed by the Congress pays for service that we give, but really an economic decision based on political priorities that these funds the Congress has passed and which it has authorized for the support of these services are that much more difficult to obtain.

Mr. CARTER. You didn't answer what percentage the Federal Government pays.

Dr. ENGLISH. In New York City, Mr. Carter, every medicaid dollar roughly represents 50 cents from the Federal Government, 25 cents from the State government, and 25 cents from the city government. So it is shared in that way.

Mr. CARTER. Thank you. I want to sympathize with you about those forms, and so forth, and all the paperwork, which is very difficult. I know you have serious problems along that line. And I appreciate very much your presentation, Dr. English. Thank you, sir.

Mr. ROGERS. Thank you.

Mr. Satterfield.

Mr. SATTERFIELD. Thank you, Mr. Chairman. Dr. English, I'm sorry other business kept me from being here when you delivered your statement. I will look forward to reading it in the transcript.

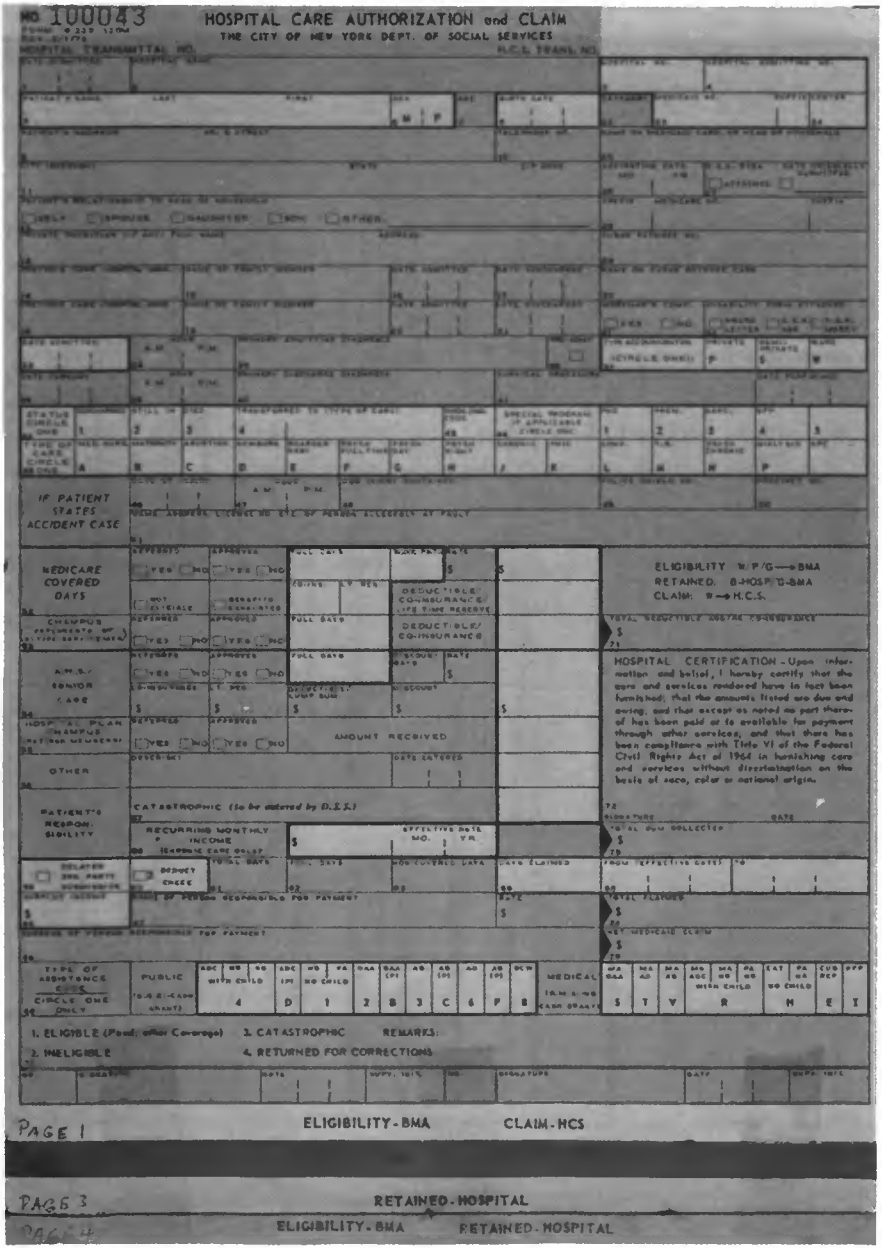
I, for one, would like to second what Mr. Carter said about the forms. I hope that you will submit them to us so that we can look at them.

Dr. ENGLISH. A pleasure, sir.

Mr. ROGERS. Without objection, they will be made a part of the record.

[Testimony resumes on p. 118.]

[The forms referred to follow:]



NO. 100043

HOSPITAL CARE AUTHORIZATION and CLAIM

THE CITY OF NEW YORK DEPT. OF SOCIAL SERVICES

HOSPITAL TRANSMITTAL NO. H.C.S. TRANS. NO.

PATIENT'S NAME LAST FIRST SEX M F BIRTH DATE

IF PATIENT STATES ACCIDENT CASE

MEDICARE COVERED DAYS

CHAMPUS

A.M.S.-SENIOR CARE

HOSPITAL PLAN (BLUE CROSS MEDICARE)

OTHER

PATIENT'S RESPONSIBILITY

RELATED INS. PARTY

TYPE OF ASSISTANCE CIRCLE ONE ONLY

PUBLIC (MEDICAID GRANT)

MEDICAL (R.H.I.P. CASH GRANT)

1. ELIGIBLE (Food, other Coverage) 2. CATASTROPHIC REMARKS:
2. INELIGIBLE 4. RETURNED FOR CORRECTIONS

ELIGIBILITY W.P/G—→BMA
RETAINED. 8-HOSP'L 0-BMA
CLAIM: 9→H.C.S.

HOSPITAL CERTIFICATION - Upon information and belief, I hereby certify that the care and services rendered have in fact been furnished; that the amounts listed are due and owing, and that except as noted no part thereof has been paid or is available for payment through other services, and that there has been compliance with Title VI of the Federal Civil Rights Act of 1964 in furnishing care and services without discrimination on the basis of race, color or national origin.

PAGE 1 ELIGIBILITY - BMA CLAIM - HCS

PAGE 3 RETAINED - HOSPITAL

PAGE 4 ELIGIBILITY - BMA RETAINED - HOSPITAL

- FOR AGENCY USE ONLY -					
SOCIAL SERVICES DISTRICT AND/OR CENTER	APPLICATION DATE Mo. Day Yr.	☐ NEW ☐ REOPEN	GROUP REFER. NO.	CASE NAME	CASE NUMBER

FORM DSS-618 (REV. 6/71) EXPERIMENTAL

NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES

APPLICATION FOR MEDICAL ASSISTANCE

Please Print clearly and complete all items. If answers are yes, give required details. If additional space is needed, see page 10.

At your interview you are required to supply proof of statements made in this application, including identity, age, place of residence, income and resources.

When Application is Completed and Signed, take or mail it to:

(Name, Address and Telephone Number of the Social Services Department)

NOTE: • The law provides for a fine or imprisonment, or both, for a person hiding facts or not telling the truth.

• A Face to Face interview is required.

PART I. FAMILY AND RELATIVE DATA

VERIFICATION DATA (For Agency Use Only)

APPLICANT'S NAME (Last, First, M.I.) ☐ MR. ☐ MRS. ☐ MISS	MAIDEN NAME	OTHER NAMES BY WHICH KNOWN

APPLICANT LIVES AT (No., Street, Floor, Apt. No., City, County, Zip Code)

MAILING ADDRESS OF APPLICANT (if same as above print same) (No., Street, Floor, Apt. No., City, County, Zip Code)

PERMANENT ADDRESS OF APPLICANT (if same as above print same) (No., Street, Floor, Apt. No., City, County, Zip Code)

I am applying for Medical Assistance because:

TYPE OF ASSISTANCE	CASE NAME	CASE NUMBER	LAST DATE RECEIVED Mo. Day Yr.	AGENCY OR CENTER
I ☐ Do ☐ Did ☐ Never Receive(d) Public Assistance				
I ☐ Do ☐ Did ☐ Never Receive(d) Medicaid				
I ☐ Do ☐ Did ☐ Never Receive(d) Food Stamps				

FORM OSS-618 (REV. 6/75)

List in this section ALL persons usually living in your home, even if in a hospital or nursing home, or away at school.

B

FULL NAME Last	First	Initial	Social Security Number or Railroad Retirement No. (See Note below)	RELATIONSHIP TO ME	SEX M/F	BIRTHDATE Mo.	Day	Yr.	MARITAL STATUS Married Single Widowed Separated Divorced	Applying for Medical Assistance Yes	No
SELF											
HUSBAND/WIFE											

NOTE: If you are receiving Social Security benefits, enter the identification number printed on your monthly check or "Medicare" I D Card. If you are not receiving benefits, enter the number from your Social Security card.

C

If this application is for a person under age 21, complete the following:

MY FATHER'S NAME Last First — ADDRESS

MY MOTHER'S NAME Last First — ADDRESS

If person under 21 is married, complete the following:

MY HUSBAND/WIFE'S FATHER'S NAME Last First — ADDRESS

MY HUSBAND/WIFE'S MOTHER'S NAME Last First — ADDRESS

D

Do any of the applicants have a driver's license? ☐ Yes ☐ No

NAME	DRIVERS IDENTIFICATION NUMBER

E Are any of the applicants or the husband or wife of any applicant in a hospital, nursing home, or other type of institution? ☐ Yes ☐ No

NAME OF PERSON	RELATIONSHIP	NAME AND ADDRESS OF INSTITUTION	DATE ADM.

F Are any of the applicants pregnant? ☐ Yes ☐ No *(Attach doctor's statement confirming delivery date)*

NAME OF PREGNANT PERSON	MONTH EACH IS DUE

G Are any of the applicants blind, sick or disabled? ☐ Yes ☐ No

PERSON'S NAME	TYPE OF DISABILITY OR SICKNESS	DATE DISABILITY BEGAN	NAME AND ADDRESS OF DOCTOR OR CLINIC

H Are any of the applicants addicts or in a drug treatment program? ☐ Yes ☐ No

PERSON'S NAME	NAME AND ADDRESS OF DRUG PROGRAM BEING ATTENDED	ENTERED Mo.	ENTERED Yr.

I Was any applicant released from an institution, mental hospital, school for retarded during the past 6 months? ☐ Yes ☐ No

PERSON'S NAME	NAME, ADDRESS AND TYPE OF FACILITY	ENTERED Mo.	ENTERED Yr.	RELEASED Mo.	RELEASED Yr.

J Are any applicants veterans, or widow(er)s or children of a veteran? ☐ Yes ☐ No

FIRST NAME	NAME OF VETERAN (If a relative)	RELATIONSHIP	ARMED FORCES SERIAL NUMBER	V A CLAIM NUMBER

PART II. LIVING ARRANGEMENT

Area 1. If you pay rent, give the following:

K

1

NAME OF LANDLORD	AMOUNT OF RENT
ADDRESS OF LANDLORD	RENT RECEIPT FURNISHED ☐ Yes ☐ No

Area 2. If you share e housing arrangement, or if you live in someone alse's home, give the following information:

2

NAMES OF PERSONS YOU SHARE WITH		
RELATIONSHIP	ARE ANY OF THESE PERSONS ON PUBLIC ASSISTANCE? ☐ Yes ☐ No CASE NUMBER _____ AGENCY/CENTER _____	
YOUR SHARE OF COST Amount _____ Per ____	NUMBER OF PERSONS LIVING IN YOUR HOME	IS THIS LIVING ARRANGEMENT? Mo. Day Yr. ☐ Permanent ☐ Temporary - Date You Must Leave By:

Area 3. If you own your own home check (✓) the one you have:

☐ House ☐ Trailer/Mobile Home ☐ Cooperative ☐ Other (specify)

3

PURCHASE OFFER	DATE OF PURCHASE	ASSESSED VALUATION (from the bill)	
NAME OF PERSON PAYING MORTGAGE	MORTGAGE PAID TO: (Name and address)		
MONTHLY MORTGAGE PAYMENT Principal _____ Interest _____	DATE LAST MORTGAGE PAID Mo. Day Yr.	PROPERTY TAX Amount _____ Per ____	SCHOOL TAX Amount _____ Per ____
FIRE INSURANCE Amount _____ Per ____	WATER Amount _____ Per ____	SEWER Amount _____ Per ____	OTHER MAINTENANCE EXPENSES (specify) 1. Amt. ____ Per____ 2. Amt. ____ Per____
ANNUAL HEATING COST	DO YOU RENT PART OF YOUR HOME? ☐ Yes ☐ No - To Whom _____	NO. OF ROOMS	NO. OF ROOMS IN YOUR APARTMENT
SIZE OF LOT AND/OR ADJACENT LAND OWNED			

L

Are there any unpaid expenses for medical services provided for applicants within the past 3 months? ☐ Yes ☐ No

Type of Service (Doctor, hospital, dental care, drugs, etc.)	Person Receiving Services	Date of Service

PART III. EMPLOYMENT

Are any of the applicants employed or self-employed (include all full time, part time, overtime and second jobs)
☐ Yes ☐ No Show pay stubs for last eight weeks.

M

Name of Person	Name and Address of Employer	Date Started	Occupation	Gross Salary	Period (wks., etc.)	Amt. of Tips

Do any of the applicants pay or have withheld from wages, any Federal, State or City income taxes, health ins. premiums, or payments ordered by a court for support of relatives? ☐ Yes ☐ No

FIRST NAME	INCOME TAX PAID OR WITHHELD						HEALTH INS. PAID		Court Ordered Payments	
	FEDERAL		STATE		CITY					
	Amount	Period	Amount	Period	Amount	Period	Amount	Period	Amount	Period
		per		per		per		per		per
		per		per		per		per		per
		per		per		per		per		per

Was any applicant employed during the past 6 months? ☐ Yes ☐ No

PERSON'S NAME	EMPLOYER'S NAME AND ADDRESS	PERIOD OF EMP. FROM Mo.	PERIOD OF EMP. FROM Yr.	PERIOD OF EMP. TO Mo.	PERIOD OF EMP. TO Yr.	GROSS SALARY Amount	GROSS SALARY Per	REASON FOR LEAVING

Are any of the applicants a present or past union member? ☐ Yes ☐ No

PERSON'S NAME	NAME, ADDRESS AND PHONE NO. OF UNION	DATE JOINED Mo.	DATE JOINED Yr.	DATE LEFT Mo.	DATE LEFT Yr.

PART IV. OTHER INCOME

Do any of the applicants have or expect to receive any of the following? ☐ Yes ☐ No

TYPE OF BENEFIT	Applied Yes	Applied No	Date Applied Mo.	Date Applied Day	Date Applied Yr.	Receiving Yes	Receiving No	NAME OF PERSON RECEIVING INCOME	AMOUNT	WEEKLY MONTHLY YEARLY
Unemployment Insurance										
Workmen's Compensation										
Veteran's Benefits or Pension										
Social Security										
Union Benefits										
Railroad Retirement										

Do any of the applicants have or expect to receive any of the following? ☐ Yes ☐ No

TYPE OF BENEFIT	Applied Yes	Applied No	Date Applied Mo.	Date Applied Day	Date Applied Yr.	Receiving Yes	Receiving No	NAME OF PERSON RECEIVING INCOME	AMOUNT	WEEKLY MONTHLY YEARLY
NYS Disability Insurance										
Court Order/Support Payments										
Income From: Rent, Produce of Farm, Roomers, Boarders, Mortgages, etc.										
GI Dependency Allotment										
Income from Relative or Friend (Give name)										
Employer Pensions										
Dividends from stocks, bonds or Life Insurance										
G.I. Bill										
Income from Training Program										
Other Income										

Q cont.

Do any of the applicants have a legal husband/wife living elsewhere? ☐ Yes ☐ No

NAME OF MARRIED PERSON IN HOUSEHOLD AND NAME OF LEGAL HUSBAND/WIFE	ADDRESS OF LEGAL HUSBAND/WIFE	SOCIAL SECURITY NO. OF HUSBAND/WIFE	SUPPORT PAID	If Yes, Amount/per	If No, Are You Willing To Seek Support
MARRIED PERSON			☐ Yes ☐ No		☐ Yes ☐ No
LEGAL HUSBAND/WIFE					

NAME AND ADDRESS OF PRESENT OR LAST KNOWN EMPLOYER OF HUSBAND/WIFE

R

Are there any parents of children living outside the home? (Include the father of unborn child) ☐ Yes ☐ No

ABSENT PARENT'S NAME	SOCIAL SECURITY NO.	HOME ADDRESS

PLACE OF EMPLOYMENT — AUTOMOBILE LICENSE NUMBER

FIRST NAME OF EACH CHILD THAT BELONGS TO THE ABSENT PARENT: 1. 2. 3. 4. 5.

DATE PARENT LEFT HOME Mo.	DATE PARENT LEFT HOME Yr.	SUPPORT REQ. Amount/per	SUPPORT ☐ Voluntary ☐ Court Ord.	LOCATION OF COURT	DOCKET NO.

Is this absent parent receiving public assistance? ☐ Yes ☐ No

AGENCY/CENTER	CASE NUMBER	WILL YOU SEEK SUPPORT
		☐ Yes ☐ No

S

Are there any parents of children living outside the home? (Include the father of unborn child) ☐ Yes ☐ No

ABSENT PARENT'S NAME	SOCIAL SECURITY NO.	HOME ADDRESS

PLACE OF EMPLOYMENT	AUTOMOBILE LICENSE NUMBER

FIRST NAME OF EACH CHILD THAT BELONGS TO ABSENT PARENT				
1.	2.	3.	4.	5.

DATE PARENT LEFT HOME Mo. / Yr.	SUPPORT PD. Amount/per	SUPPORT ☐ Voluntary ☐ Court Ord.	LOCATION OF COURT	DOCKET NO.

Is this absent parent receiving public assistance? ☐ Yes ☐ No

AGENCY/CENTER	CASE NUMBER	WILL YOU SEEK SUPPORT
		☐ Yes ☐ No

The following people live with me and are NOT applying for assistance:

FULL NAME (First, Middle Initial, Last)	RELATIONSHIP TO ME	Sex M/F	SELF SUPPORTING	If self-supporting, is he contributing to support of household	If Yes, Amount/per	If Already Receiving Public Assistance give	
						CASE NO.	CENTER/AGENCY
			☐ Yes ☐ No	☐ Yes ☐ No			
			☐ Yes ☐ No	☐ Yes ☐ No			

PART V. RESOURCES

Do any of the applicants have the following:

TYPE OF RESOURCE	Yes	No	NAME OF PERSON OWNING RESOURCE	NAME AND ADDRESS OF BANK	ACCOUNT NO.	VALUE OF RESOURCE
Cash on Hand						
Bank Account(s) 1						
2						
Pending Lawsuit Which May Result in Cash Award						
Credit Union						
Stocks/Bonds						
Trust Fund						
Safe Deposit Box						
Union Benefits (including Life or Health Insurance)						
Other (Specify)						

U Do any of the applicants have the following:

TYPE OF RESOURCE	Yes	No	NAME OF PERSON OWNING RESOURCE			FACE VALUE	CASH VALUE
Life Insurance 1			INSURED	INSURANCE CO.	POLICY NO.		
			TYPE OF INSURANCE	BENEFICIARY	DATE OF ISSUE		
2			INSURED	INSURANCE CO.	POLICY NO.		
			TYPE OF INSURANCE	BENEFICIARY	DATE OF ISSUE		
3			INSURED	INSURANCE CO.	POLICY NO.		
			TYPE OF INSURANCE	BENEFICIARY	DATE OF ISSUE		
Burial Fund			NAME OF PERSON OWNING RESOURCE			VALUE OF RESOURCE	

V Do any of the applicants own property other then listed in Section K? ☐ Yes ☐ No

DESCRIPTION OF PROPERTY	VALUE OF PROPERTY
LOCATION OF PROPERTY	

W Have any of the applicants transferred or sold any real or personal property during the year prior to this application? (Bank Accounts, Stocks, Bonds, etc.) ☐ Yes ☐ No

NAME OF PERSON	DESCRIPTION OF PROPERTY	VALUE	TRANSFERRED OR SOLD TO

X Are any of the applicants in receipt of Medicare? (Health Insurance of the Social Security Administration) ☐ Yes ☐ No

NAME OF PERSON	ENTER NUMBER & LETTERS FROM MEDICARE CARD	ENROLLED FOR MEDICARE PART A (yes or no)		ENROLLED FOR MEDICARE PART B (yes or no)	
		☐ Yes ☐ No	DATE	☐ Yes ☐ No	DATE
		☐ Yes ☐ No	DATE	☐ Yes ☐ No	DATE

Y Are any of the applicants covered by Health Insurance? ☐ Yes ☐ No
(You must list all health insurance coverage carried by an absent parent or husband/wife.)

NAME OF PERSON COVERED	INSURANCE CO.	IF GROUP INSURANCE, GIVE NAME OF EMPLOYER	DATE OF COVERAGE	PREMIUM		POLICY NO.
				Amount	Period	

PART VI. OTHER APPLICANT INFORMATION

The following question is being asked for research purposes in accordance with the Civil Rights Act of 1964 and at the request of the Federal Government. If you feel that the description Negro, White or Puerto Rican does not apply to you, you may check the "Other" box and write in what you prefer to be considered. You may choose not to answer the question. I am ☐ Negro ☐ White ☐ Puerto Rican ☐ Other (specify) _____

Each applicant in receipt of Medicare sign this request

I wish payments under the Supplementary Medical Insurance Program (Part B of Title XVIII or "Medicare", to be made directly to physicians and medical suppliers on any future unpaid bills for medical and other health services furnished to me while I am eligible for Medical Assistance.

SIGNATURE OF PERSON OVER 65	DATE	HUSBAND/WIFE SIGNATURE	DATE
X		X	

PART VII. CERTIFICATION

APPLICANT	REPRESENTATIVE
I hereby apply for Medical Assi. ance for the person indicated in Section C of this form and certify that all of the information contained herein is true and correct to the best of my knowledge and belief and that no facts have been omitted. I make this application with the understanding that: I will furnish any additional information which may be required; I will report immediately, any changes in circumstances, including changes in financial resources; I will assist in filing or or file any claims for health or accident insurance benefits to which I am entitled; and I will make any required assignment of such benefits to the social services official to whom this application is submitted. I understand that my application may be investigated and I agree to cooperate in such an investigation. I further understand that the law provides for fine or imprisonment, or both, for a person hiding facts or not telling the truth.	I hereby submit this application for Medical Assistance on behalf of the applicant named above, and furnish the information contained in the application based upon knowledge and information obtained from the applicant and other sources. The information furnished is true and correct to the best of my knowledge and belief. This application is submitted with the understanding that the certification of the applicant may be required and that such certification will be obtained if required.
SIGNATURE OF APPLICANT / DATE X	SIGNATURE OF REPRESENTATIVE / DATE X ADDRESS OF REPRESENTATIVE

FORM D35-815 (REV. 4/78)

Give directions to the place where you live.

Use this section for additional space to answer any previous questions. *(Refer to previous section by letter)*

St. Pg. Road

Mr. ROGERS. Mr. Hudnut?

Mr. HUDNUT. Thank you, Mr. Chairman. I appreciate the testimony of both you gentlemen, and it has been very informative to me as a newcomer to this committee and to the Congress. I do note that both of you have been associated with the present administration, but left it. I am wondering if there is any reason you could share with us. Is it because of disillusionment with the management techniques that are being applied in HEW? Is it because you feel that the situation is an impossible one to work in creatively because of certain new management techniques? Is it because you believe that the will of the Congress is being, to use your word, flouted deliberately and that this is an intolerable situation so far as your own conscience is concerned? I would be interested in any elaboration you could give our committee as to your reasons for severing your connections with the administration.

Dr. MACLEOD. That is a very challenging question, Mr. Hudnut. From my own vantage point my resignation was precipitated by the action of the administration to reduce or downgrade the HMO Service from a program at the national level to a desk function. I did not resign precipitously. I resigned after many professionals inside and outside Government had made every effort to discuss the issues, the problems, and the concerns with the Department's representatives. Still, the decision was made to downgrade the program to a desk function. This creates particular problems for a small program or for one awaiting legislation.

Decategorization of the HMO Service puts it into competition at the desk level with all the other desks such as the National Health Service Corporation, the Maternal and Child Health Care Services, Family Planning Services, Migrant Health, and the neighborhood health centers. This kind of organization is going to cause a type of destructive competition so that the squeaky wheel gets the oil. The new desks shall not have responsibility for budget and for manpower resources. In the future those responsibilities will be shifted to new categories, such as organizational development, policy development, monitoring and analysis, and so forth. And without the kind of direction that can be provided by a program on both staff and budget, my own decision was that the HMO desks would not provide an opportunity to run an effective program. So, therefore, after weeks of discussion, I announced my resignation.

Dr. ENGLISH. Sir, I welcome an opportunity to respond to that question, and the answer that I give goes back 3 years and represents the fact that I was the Administrator of the Health Services and Mental Health Administration for the last year of Mr. Johnson's administration and for the first year of President Nixon's administration, having served before that in the Federal Government altogether about 10 years. Prior to being with HEW, I was Assistant Director of the Office of Economic Opportunity in charge of the health care programs like neighborhood health centers, family planning, and so forth.

I can tell you that one of the significant differences that began to occur when the new administration came in was the access I would have as a top professional in the Federal Government to the Congress. Never before in my experience in the Federal service was I not given the opportunity to represent directly the accountability I felt I had

not just to the executive branch of Government, but to the committees of the Congress that had responsibilities in this regard. All I can say is that we began to experience in the first year of this administration some inhibitions in that regard that made it very difficult to carry out my sense of what a top carrer official in health care delivery services in the Federal Government had as an expectation of his role.

I will never forget in the early days of Secretary Finch's tenure, that at his encouragement, when we took some of the health care legislative initiatives for consideration by the Budget Bureau, people in the Budget Bureau saying "how can all of you over in HEW work out health care programs before the President works out what his economic strategy is going to be?" I will never forget Mr. Herbert Klein being present at that meeting and raising that question. I wasn't sure what he meant at the time. We soon came to learn that the economic strategy was going to mean a massive reduction in Federal spending in health, and no matter what the rhetoric claimed. New program initiatives were not welcome because they really meant evacuation of present programs and suggesting new ones that were necessary in terms of the Nation's need. So that level of priority became apparent very soon.

But I think the straw that broke the camel's back was the issue of the politicalization of HEW itself. It was made very clear to me that it was felt that the top administrator of the Health Services and Mental Health Administration should not be a career official of the U.S. Government, as had been the conceptualization of Mr. Gardner's reorganization of HEW. And when it became clear that what they wanted to do was make a political appointee the head of HSMHA, NIH, and the other top agencies, that they wanted me to recruit people who were political appointees the agency head, causing a politicalization process without precedent of these agencies. That is when I left for New York City, having submitted my resignation.

Mr. HUDNUT. Thank you. If I may pursue this for just a minute—are you short of time?

Mr. ROGERS. Go ahead. We do have a panel, but you may proceed.

Mr. HUDNUT. If I may ask you cone more question, how do you view the relationship between HEW and this committee? You have used the phrase "congressional initiative." You, sir, have implied that the intent of the Congress is sometimes at odds with the bureaucracy in HEW. Which is the cart and which is the horse? Or put it this way, do you feel that the legislative branch should develop the policies which the executive should then implement, or do you think that so far as the executive itself is concerned it has the freedom and the authority to develop and implement policy on its own irrespective of what this committee might desire or the Congress might desire?

Dr. MACLEOD. Briefly, as far as management principles are concerned there are any number of ways of getting a job done, but I think it is clearly the responsibility of this committee and of the Congress to develop the policy that the administration is then responsible to execute. They then have certain degrees of freedom within which they can work, and it is this issue that I have tried to highlight; for that is one of the problems that exists between the administration and the Congress. In this sense I think the career bureaucracy does not like to find itself in the uncomfortable position of sometimes

not being consistent with the intent of Congress, as I tried to analyze in my statement.

Mr. HASTINGS. Would the gentleman yield? Both of you gentlemen worked for a long time, I take it, in HEW, or at least for a substantial amount of time. You know, we talk about what the Congress does and how we should have the initiative, but you know both, I am sure, that we today have authorized programs in HEW alone that if fully implemented would take an additional $250 billion. Now how would you equate the two? Now it is all right to sit there as ex-HEW officials and criticize the relationship between HEW and the Congress, but you both know Secretary Weinberger has stated, and it is backed up with figures, if you fully implement everything we have given you—and I might say quite often at the request of people in the bureaucracy—that you will come up with an annual budget increase of $250 billion, which equals almost our current Federal budget.

Dr. ENGLISH. Well, let me speak to that, Mr. Congressman, because I believe it is a good point.

Mr. HASTINGS. I know it is a good point.

Dr. ENGLISH. My own feeling is that the executive branch of Government ought to take the initiative in proposing to the Congress its view of what the Nation's needs are. I think part of the reason you have the reaction in the Congress which can lead to some of the problems that you have talked about is because the executive branch of Government has failed to do that adequately in recent years, and that what the Congress is reacting to, and in a way that it can't because of the way it is structured, is in effect a default of the executive branch in this regard, and I think that poses a problem for the country.

Part of the reason why I support this reorganization is because I think that Assistant Secretary Edwards as a strong Assistant Secretary will not only be helpful to the executive branch, but helpful to the Congress in this regard as well. If somebody else were the Assistant Secretary I might not feel that way. But I think he will.

I think that once the executive branch has brought proposals up here which the Congress then passes on and makes the law of the land, not only in terms of the way in which the programs are to be administered, but the amounts of money to be used, then it is the duty and the responsibility of the executive branch to respond to that mandate. Our problem is that neither of those things are happening right now, and that is why we have a congressional reaction. The executive branch has been deficient in proposing to the Congress the things that are important for the Nation's health care needs.

Mr. HASTINGS. Well, it's awfully easy, of course, to sit in an agency or in the connection you have got today and talk about lack of money primarily as being the major problem but I don't see it coming up or anybody else saying, "Let's increase taxes, then, to pay for it," and that's our problem.

We are $5 billion in the hole over and above our own limitation right today. The Congress, this Congress passed a limitation on spending. We are $5 billion over it today.

Now, you know, why don't you stand up and say, "Let's increase taxes, then, to pay for the extra money and health care we all feel we need"? I don't think anybody on this committee doesn't think

we need more but somewhere along the line we are going to have to raise the money to pay for it.

Dr. ENGLISH. Mr. Congressman, I couldn't support that proposition without an opportunity to explain——

Mr. HASTINGS. I'm sorry, it sounds a little bit like the ins and outs. I will yield back to your time.

Dr. MACLEOD. Mr. Hastings, may I respond to your charge of ins and outs and increased taxation?

Mr. HASTINGS. Sure.

Dr. MACLEOD. The HMO activity has shown consistently over the past several years it is able to provide health care at a reduced cost and I think that the decategorization of the HMO program now may lose some of the impetus that has been gained by the administration's initiative to reduce the cost of health care services that wouldn't require additional Federal money in the long run. This is not a question of ins and outs, rather one of an effort toward cost effectiveness.

Mr. HASTINGS. I will respond to that that I think the committee is well aware of the potential of the HMO. We worked on it long enough and hopefully at 11:45 a.m. today we are going to have an opportunity to implement what the committee has been working on. Believe me, I am very much convinced of the efficacy of HMO's and I am sure this entire committee is.

Mr. CARTER. Will the gentleman yield?

Mr. HASTINGS. Mr. Hudnut has the time.

Mr. HUDNUT. I will yield.

Mr. CARTER. You yield?

Mr. HUDNUT. Yes, sir.

Mr. CARTER. Thank you, sir.

What are you doing at the present time, please, sir? What is your——

Dr. ENGLISH. I am president, Mr. Carter, of the New York Health and Hospitals Corp.

Mr. CARTER. Health and Hospitals Corp.?

Dr. ENGLISH. Yes, sir.

Mr. CARTER. Tell me something about this organization, please, sir.

Dr. ENGLISH. Yes. It is a public benefit corporation set up by the law of the State of New York which manages the 19 municipal hospitals of New York City which is the major source of health care for about 2 million people in New York City and which is beginning to assume the personal health care services of the health department and the mental health department with an eye toward developing comprehensive health care services for the citizens of New York City.

Mr. CARTER. For all the citizens or just partiular groups of citizens?

Dr. ENGLISH. Well, the mandate of the law which creates us limits us to no particular group. It says that we should be the body created by the State legislature to be concerned about all the citizens of the city of New York. But our primary concern are those people that cannot be served by voluntary hospitals for one or another reason—their inability to pay—and so we, therefore, have a major responsibility for the 1½ to 2 million poor people in New York City.

Mr. CARTER. Are these people getting adequate care now?

Dr. ENGLISH. In my judgment, sir, no, they are not.

Mr. CARTER. Thank you, Mr. Chairman.

Mr. ROGERS. Thank you. Mr. Kyros?

Mr. KYROS. Thank you, Mr. Chairman. In the interest of time and particularly because I believe we should listen to the distinguished panel that is here, as I understand we are having a 11:45 a.m. markup session in the full committee, I will ask no questions at this time.

Mr. ROGERS. Thank you. Mr. Nelsen, did you have any——

Mr. NELSEN. No questions at this time.

Mr. ROGERS. Mr. Roy?

Mr. ROY. I would like to thank you for your presentations and I would like to ask you, Dr. MacLeod, a little bit about how the HMO service worked formerly and how it will work under the new organization.

You state it has been reduced to a desk function of five or six people. Now—and then we have seen the organization charts of the health services administration with the box for health development, organizational development, and so on. Formerly, if you wanted to develop policy with regard to HMO's how would you develop policy? Or if you wanted to develop organization, how would you develop organization?

Dr. MACLEOD. Briefly, the HMO service was set up as a program activity within HEW. There was a director and three divisions that were responsible for carrying out the functions of the program. The director was assisted by an executive officer who had responsibility for administration, grant, and contract activity. The director also had responsibility for accounting for the funds expended by the program.

The three divisions directly responsible for the operating functions of the HMO service were the technical assistance division whereby developing HMO'S were provided technical assistance, the health services delivery division, which was concerned with quality assurance and manpower problems in HMO's, and the office of consumer affairs called the office of consumer education and information. There was also a project management or monitoring activity housed within the HMO service.

In addition, there were three, four, or five people in each of the regional offices who extended the central office activity. The combined central and regional office staff were able to carry out and implement the policies and the programmatic decisions made at the central level.

Mr. ROY. Now, let me ask under the new program, the new reorganization program, if you wanted to have technical assistance, where would you turn? Would you turn to the other five people on the desk or would you turn to the health services administration and one of the five delineated areas within that service?

Dr. MACLEOD. My understanding is that the desk will probably have two or three professionals and two secretaries or clerical personnel, plus an assistant bureau chief who will oversee the activities of that desk, so there may be as many as four people to carry out professional duties.

The basic responsibility of this unit will not be for grants and contracts, nor for financial accountability, but will simply be for coordinating the HMO activities, calling upon the much larger and more

cumbersome units of policy development, organizational development, monitoring and analysis, clinical services, et cetera.

The bulk of the activity in these decategorized areas will be reported to top management which will have control over all contract and grant activity that presumably will be initiated by the efforts of small coordinating groups at the desk level.

Mr. ROY. If you wanted someone in policy development to do something to move ahead with HMO's and you asked them to do so and they say "No," then what is your recourse under the new organization? Do you understand what your recourse would be?

Dr. MACLEOD. I don't, Mr. Roy. The reason that I don't is that there is no precedent within the health services delivery arm of government for this particular type of organizational arrangement. But let us examine, for example, the decategorized area of policy development.

My guess is that under any circumstance where you would have a problem in this area, the person on the desk will go directly to the assistant bureau chief, who in turn will report it to the bureau chief, who then will direct the policy development chief, who will translate the message to his division chief, who will then direct action at the branch chief level. You will find yourself now going up and around the horn in order to get policy development accomplished.

Mr. ROY. So I assume if the bureau chief says the chief of the health services administration says, "Yes, we would like to do this," then he would go to policy development and policy development said, "Well, Mr. Bureau Chief, we are busy developing policy for Indian Health or National Health Service, and we can't possibly do it unless we drop what you asked us to do 2 weeks ago," he would come back to you and say, "This can't be done at this particular time and could be done at some other time"? Is this about the way——

Dr. MACLEOD. I think that is a reasonable conjecture of what could happen under this particular management organization.

Mr. ROY. Now, in the regional office, is it your understanding that the people in the regional office will report directly to the director of the HMO desk or will they report to their regional director who will report to the assistant secretary and will go up and around that horn again?

Dr. MACLEOD. The letter is correct, although I think it is fair to say that the transition toward this activity has been going on for the past few years, and we have had a bifurcation of responsibility between the central and the regional offices during that time, whereby the regional office personnel reported to the regional health director, who in turn reported to the regional director, but at the same time there were very close linkages back to the program level at the central office. These linkages required strong nurturing by the program.

Mr. ROY. Does this, in your opinion, offer a greater danger to new program initiatives such as HMO or such as PSRO than it offers the established programs such as Indian health service or neighborhood health centers or family health centers?

Dr. MACLEOD. Decategorization has not affected all of the program activity within HSMHA but it has affected a large group of service activities, so I think it is probably going to have the greatest impact on that group I mentioned, specifically the national health service

corps, family planning, maternal and child health, neighborhood health centers, migrant health, and HMO's.

Mr. ROY. We pay our respects or we indicate our regard again and again to having professional people running these highly sophisticated programs in order that they may deal with the skilled people in the private sector, in State government and so on.

There have been indications that many people, many professionals in government are there because they see the opportunity to accomplish some goal that they think is good for medicine or the American people or both.

I think I can say freely that in my brief time here I have seen this feeling with regard to you. I certainly have this feeling with regard to Dr. Bauer, who came in in the PSRO service. There are indications that this reorganization will be destructive to the exercise of the professional judgments of the individuals who are coming in in an attempt to organize and execute these programs.

May I ask you how you find the morale to be over at HEW at the present time among the professionals who will be asked to execute programs under the reorganization?

Dr. MACLEOD. Well, morale during any reorganization is going to be a problem. I think specifically during this reorganization the resignation, retirement, or reduction in status of one-third to one-half of the former program directors within HSMHA has created a sense of impermanence and a lack of stability within that agency or its successor agencies.

As one example of increasing demoralization I am reminded of an anecdote which I think is worth recounting and that is that a senior woman executive in HEW approached me in the corridor in front of the executive suite of the Parklawn Building, grasped my hands in both of hers and said, "Congratulations, Dr. MacLeod. I only wish that several other of us could do what you are doing." Similarly, I have received correspondence to this effect both from inside and outside the HMO Service.

There is, in addition, a specific problem with any type of reorganization and that is personnel reassignment and the considerations of program identity for such personnel.

If the personnel have identified with the program and, therefore, work a little bit harder, a little bit longer, and maybe an occasional weekend, it's possible when they are doing it for HMO's or family health centers or maternal and child health or family planning, but if organizational development, policy development, or monitoring and analysis is where the great bulk of effort is going to be, I think there will be a much more difficult process of indentification for personnel working in these new units, thus negatively affecting productivity and morale.

Mr. ROY. Thank you, Dr. MacLeod. Dr. English, I had just a couple of questions that I wanted to ask you.

In a HEW working paper on reorganization, it stated:

> There are serious differences between regional offices and headquaters staff with regard to the manner of achieving objectives. Headquarter programs have viewed some efforts in integration as obstacles to the achievement of national programmatic objectives.

Now, I read this to say that headquarters staff is always or almost always anxious to carry out the program as directed by the Congress and that the regional staffs find this to be very difficult at times and

they respond negatively to this attempt. Is this true? Is this your experience?

Dr. ENGLISH. I think it certainly can be because I don't think the regional staff deals with the Congress by and large. I don't think it is as aware as the central program leadership would be of the congressional intent or executive branch intent.

Mr. ROY. Do you feel that decentralization can be used to avoid congressional intent?

Dr. ENGLISH. Yes, sir; I do.

Mr. ROY. A second thing I wanted to ask you about is the statement in the same paper which states:

> The fact that regional offices receive separate allocations tied to individual appropriations instead of a consolidated operating budget is viewed as a constraint to their ability to integrate activities.

I asked the question yesterday and unfortunately, there wasn't time, as to whether or not it is planned that regional offices would get consolidated operating budgets. Now, I think you have probably forgotten more about most of the presently operating health legislation than I have been able to learn in the brief time I have been in Congress but may I ask you, do you believe that it is possible under the present laws to provide consolidated operating budgets to the regional offices?

Dr. ENGLISH. No, sir, not if one is to fulfill adequately the program intent or the congressional intent. It seems to me if the executive branch wants to have greater flexibility in utilizing budgets appropriated to it by the Congress, then it has the responsibility of going to the Congress and saying that—explaining the case for it and getting the laws changed so it can be possible. That can be done and I don't think that the way to handle that problem is to in effect subvert the intent of the law administratively by creating a management situation in the regional offices where the Congress is going to have infinitely more difficulty in maintaining the accountability and in fact, doing something which may fly in the face of congressional intent.

I do think that is the way, under the law of the land, we ought to approach things.

Mr. ROY. Do you think the feeling that this might be an attempt to accomplish administratively that which has not been accomplished legislatively is an indication of paranoia and high suspicion or do you feel we really have some facts upon which to base this type of an, at least caution with regard to this happening?

Dr. ENGLISH. Well, sir, I think, and I must say this is my personal opinion, that it is not only an effort to accomplish administratively what may be questionable both programmatically and in terms of legislative intent but I would go further than that and say it is part of a political strategy. It is extremely difficult for the Congress to receive from that kind of administration the accountability which under our form of government, is proper. So I feel it is not just an administrative strategy, but is part of a political strategy that I got some understanding of in the very early days of the new administration.

Mr. ROY. Do you think the Congress has the power to act to thwart this reorganization?

Dr. ENGLISH. Yes, sir. I think that is very relevant to this issue of reorganization with which you are conerned. I would be less concerned about trying to organize the executive branch from the standpoint of a congressional committee. I think that you understand the problems that you have in trying to do that.

Part of the reason why I support this reorganization is because, I know the professional and personal integrity of Dr. Edwards. I worked with him before he came into the Federal Government and I worked with him as a peer in the Federal Government and I think that what he is trying to do in developing a strong Assistant Secretary for Health is something that really has been evolving long before his tenure and there is great need for it.

It seems to me the implications of that for the committees of the Congress is to make him accountable and to insure—because in the construct of his new office there is no question who is accountable to the Congress for the relevant laws being executed. I think that protects him from political thrusts that have to do with decentralization and other kinds of things over which he has effectively no control. You can strengthen him in such ways that he, as the top health officer of the U.S. Government, is not a victim as I have seen other men in his position become.

Mr. ROY. I very much appreciate your statement and your answers to my questions. I feel that it is extremely important that you have emphasized to us the strengths which the Assistant Secretary should be able to achieve if we are going to have an effective administration of health programs, and I share with you your high regard for Dr. Edwards. The things that I heard and the things that I felt at the time of his appointment were that everybody here in the Congress and generally within Government were very pleased by this appointment of Dr. Edwards to the Assistant Secretary for Health.

It appears to me that we have sort of a half-a-loaf situation. We would sort of like to take the top level reorganization which strengthens Dr. Edwards but I think it is not in the best interest of health programs to take the lower level decentralization political reorganization of HEW, which will, I believe, make it difficult for the Congress and will make it difficult for any new programs to be established because I am afraid that with diffusion of these programs and without individuals answerable to the director of the programs that the enemies of the program will have many-fold increased opportunities to destroy those programs. I think if we are going to move ahead with the only two important initiatives in the last 5 years in the health care field, that is PSRO's and HMO's, we are going to have to do something to make sure those two services are strong services and the progessionals who head up those services have the funds to move ahead with those programs.

Thank you, again.

Mr. ROGERS. Mr. Nelsen, do you have some——

Mr. NELSEN. In the statement, you are Dr. MacLeod?

Dr. MACLEOD. Yes, sir.

Mr. NELSEN. I note your reference to HMO's the past 2 years is based on the 44-year history of prepaid group practice plans. Now, I didn't realize that HMO's went back 44 years. How did they get organized 44 years ago, 10 years ago, 5 years ago?

Mr. Carter. Mr. Chairman, will the distinguished gentleman yield?

Mr. NELSEN. I will be happy to.

Mr. CARTER. We may have had groups which under another name were HMO's. Actually, the name "HMO's" was invented in 1971.

Mr. NELSEN. Yes, I know that, but I mean the system is what you are talking about, not the name that may be given, but anyway, they have existed for a long time, Dr. MacLeod, have they not?

Dr. MACLEOD. The history of HMO's dates back to the beginning of the prepaid group practice plans. There were two founded in 1929 and another one in 1937. A few began after World War II, and today there are, or as of 1970, some 30 HMO's, or prepaid group practice plans that later were to be called HMO's.

These organizations generally came into being in a number of ways. One was through a cooperative arrangement whereby a local cooperative set up the plan which gradually grew; another was industry-sponsored; a third was sponsored by individual physicians in solo practice particularly in the case of the medical care foundation of which the San Joaquin Medical Care Foundation in California is the forerunner.

These organizations almost always met with great difficulty in obtaining the initial funding necessary to get them off the ground because of the shortage of front-end money. But oftentimes they pieced together sufficient funds to get the planning of the program going which usually took 2 or 3 years. The program was then able to to grow on its own after an additional 2 or 3 years of deficit operation.

The limited number of HMO's over a 40-year period reflects the difficulty in getting HMO's going.

Mr. NELSEN. Now, through the hearings on HMO we became aware that without question many of them have done a very fine job. I always think of the one up at Two Harbors, way up in the sticks, shall we say, and that has been very successful. It has performed a service and they have done it on their own.

Throughout the hearings on HMO, it has always been my position that whatever we do should not be setting one group up with a financial advantage over another group and that the existing health delivery systems should not be put at a disadvantage by subsidy to another.

Now, I have no objection to establishing feasibility, studies to try to lay out the structure, to help in that way, but when you start going beyond that, then you begin to put other systems at a disadvantage.

We tried to move in that direction in the proposal that we have finally worked out but I want to call attention to your reference to impoundment of funds and refers to the gosh-awful situation where dollars are held back.

Well, I learned that the medical school in the State of Minnesota, we had part A, B, and C. You may know a little bit about the background. A is approved, B and C coming up to meet our requests for more doctors. I learned that the School of Veterinary Medicine is not getting the money that we committed to them.

I learned that our new start medical schools aren't getting their money so at a breakfast meeting of the board of regents, University of Minnesota, and Malcolm Moos the president of the University of Minnesota, came in and they laid their cards on the table. Then we considered the HMO the same day and I voted no because we were

adding more than we could fund and we weren't funding what we already had, so we have reduced it and we have reduced some of the terms in the bill and I believe we now have a saleable, liveable, attainable level in the HMO bill. So it isn't always easy in this area of Government and I have been in it along time, much longer, I think, than most any member of this committee, and I have seen this time after time, and therefore I try to proceed toward a goal that is attainable, one that you can sustain also, and that's what we have been trying to do.

I notice that the last paragraph on page 4, you refer to, "Moreover, it seems ironic that the new breed of managers could fumble in laying the groundwork."

Now, I wondered about the "new breed," what you have in mind. Have you somebody in mind down there that is in that category of a new breed? I wondered if you had any particular person you wanted to identify.

Dr. MACLEOD. Well, I expressed my concern in the context of the material in my opening statement that there is an obvious problem with the appointment of management people without health experience having to make decisions about health care delivery and health care services. At least one action of that kind was publicly announced in the newspapers—in the Washington Post on May 5.

Mr. NELSEN. Now, on the impoundment thing, I'd like to make some comment——

Mr. HASTINGS. Before you do, would the gentlemen yield?

Mr. NELSEN. Yes.

Mr. HASTINGS. Did Procter & Gamble ever hire management people that didn't know how to make soap?

Dr. MACLEOD. I think it's fair to say yes, sir.

Mr. HASTINGS. I think they probably did. I understand you worked for them.

Dr. MACLEOD. Yes, sir.

Mr. HASTINGS. I did, too, incidentally, but it's not unusal to have top management people who are not necessarily experts in the field they are going to manage. That is my only point. Thank you for yielding, Mr. Nelsen.

Dr. MACLEOD. I agree with you wholeheartedly that management personnel are necessary in the health services field. The question is whether they are going to have to be put in the position to make decisions with respect to health care services and health care delivery with absoultely no experience in the health care field.

Mr. NELSEN. Another question——

Dr. ENGLISH. Could I just make one comment because I can't resist. I think one of the problems sometimes that Dr. MacLeod is speaking to is that sometimes management people, and I don't mean to be prejorative about them because we need them, can confuse the delivery of health care with the making of soap, and I think that was his point.

Mr. NELSEN. Kind of clean it up a little; is that it?

On the impoundment provision, I believe the Congress of the United States consistently likes to pass the buck to the President on his right to freeze funds and do things. I want to, for the record, refer once more to the debate on the floor of the House on the ceiling on spending dur-

ing which Wilbur Mills, a Democrat, made a speech and he said that we have got to quit doing this and that we are not meeting our responsibility, we are not showing restraint, and if we keep on the way we are going we are going to run into trouble.

The next speaker was Bill Colmer, chairman of the Rules Committee, a Democrat. He said the same things; we are at the crossroad. Next was George Mahon, chairman of Appropriations, a Democrat, and he said the same thing.

When it comes to impoundment and budget control, there is an executive responsibility, there is a legislative one, and that's the why it ought to be. Now, some funds have been withheld but most of your HEW budget is uncontrollable. You have only a limited dollar figure—I think it is $12 billion of the $80 billion—only $12 billion of discretionary authority and we keep adding program on top of program and many are good and I would like to have all of them but you simply don't have the dollars there to do it. I am only saying this because I am sure that you recognize as we do and I am sure in the area of reorganization that there is bound to be some area that could have been better designed but these evolve by experience.

Now, I ran REA and we reorganized a couple of times. I had some leaks down in my Department. I cured them, really soldered them up good, but sometimes you need to reorganize and I'm sure we know that there are times when that's necessary. I thank the gentlemen now. There is no charge for the speech but I had to get it off my chest.

Dr. MacLeod. May I speak to that point, sir?

Mr. Nelsen. Yes.

Dr. MacLeod. My opening statement was directed toward organizational management concerns within the Department. I made no mention of impoundment or of fiscal concerns or of political concerns. I was highly specific with respect to organizational management and I should like to echo and reinforce the concerns expressed by Dr. English about the need for medicaid and medicare to be under the direction of someone as competent as Dr. Edwards. I should like to repeat my commendation of the reorganization with respect to the Office of the Assistant Secretary of Health and with respect to the reorganization or restructuring of HSMHA into three new agencies. But with respect to the last two tiers of reorganization, namely, decategorization and regionalization, I think specific questions have to be raised and looked at by this committee and I appreciate the opportunity to appear before you.

Mr. Nelsen. Thank you. Thank you very much. Pardon me.

Mr. Rogers. Thank you very much. Your testimony has been most helpful to the committee. We are grateful for your presence here today.

Dr. English. Thank you, Mr. Chairman.

Dr. MacLeod. Thank you, Mr. Chairman.

Mr. Rogers. The committee expresses its thanks.

I might say I see in the audience a former Assistant Secretary for Health who had a distinguished career in Government and I would like him to stand and allow the committee and those present to recognize him. Dr. Du Val.

[Applause.]

Mr. Rogers. I know the panel is not going to be pleased with this and I am sorry to have to say it but we do have a full committee

meeting that is most important and if you will bear with us and could return at 2 o'clock——

Mr. NELSEN. Couldn't we finish up now, Paul?

Mr. ROGERS. I would not want to have you violate your duty to the full committee, so under those circumstances we will adjourn until 2 o'clock this afternoon.

[Whereupon, at 11:45 a.m., the hearing was recessed, to reconvene at 2 p.m.]

AFTER RECESS

[The subcommittee reconvened at 2 p.m., Hon. Paul G. Rogers, chairman, presiding.]

Mr. ROGERS. The subcommittee will come to order. Other members are on their way, but I think we will get started at least, and get the pannel situated where we can begin. We welcome those members of the panel and would appreciate your coming to the table.

Dr. John A. D. Cooper, president of the Association of American Medical Colleges; Dr. Donald Cornely, professor and chairman, Maternal and Child Health, Johns Hopkins University School of Hygiene and Public Health; Mrs. Jeanne Rosoff, director of Planned Parenthood Federation of America; Dr. Eileen M. Jacobi, executive director, American Nurses Association, accompanied by Mrs. Constance Holloran—and we will be glad for you to sit at the table with them—and Dr. I. Lawrence Kerr, who is representing the American Dental Association, accompanied by Mr. Hal M. Christensen, director of the Washington office.

We welcome all of you and we are sorry the hearings this morning took so much time so we have had to delay you in giving your testimony. We apologize for that, but it couldn't be helped this morning.

However you desire to proceed will be fine. Dr. Cooper, did you want to start us off?

STATEMENTS OF DR. JOHN A. D. COOPER, PRESIDENT, ASSOCIATION OF AMERICAN MEDICAL COLLEGES; MRS. EILEEN M. JACOBI, Ed. D., R.N., EXECUTIVE DIRECTOR, AMERICAN NURSES ASSOCIATION, ACCOMPANIED BY CONSTANCE HOLLORAN, DEPUTY EXECUTIVE DIRECTOR; DR. I. LAWRENCE KERR, IN BEHALF OF THE AMERICAN DENTAL ASSOCIATION, ACCOMPANIED BY HAL M. CHRISTENSEN, DIRECTOR, WASHINGTON OFFICE; MRS. JEANNIE I. ROSOFF, DIRECTOR, WASHINGTON OFFICE, PLANNED PARENTHOOD FEDERATION, INC.; AND DR. DONALD A. CORNELY, IN BEHALF OF THE AMERICAN ACADEMY OF PEDIATRICS

Dr. COOPER. We haven't caucused or anything, Mr. Chairman, but if it is agreeable.

Mr. ROGERS. And I might say we will make your prepared statements part of the record if you would desire.

Dr. COOPER. Mr. Chairman, the Association of American Medical Colleges welcomes this opportunity to comment on the need for sound organization and administration of Federal health programs in the context of the July 1, 1973, administrative reorganization of the Health

Services and Mental Health Administration in the Department of Health, Education, and Welfare.

Now in its 97th year, the association represents the whole complex of persons and institutions charged with the undergraduate and graduate education of physicians. It serves as a national spokesman for all of the 114 operational U.S. medical schools and their students, 400 of the major teaching hospitals, and 51 learned academic societies whose members are engaged in medical education and research. The association and its membership thus have a deep and direct interest in the organization and administration of Federal health programs.

The medical schools receive Federal assistance through congressionally enacted programs from a number of departments and agencies. The principal source of assistance is the Department of Health, Education, and Welfare. Within the Department, the principal agencies providing funds are the National Institutes of Health—through its research and education assistance programs—the former Health Services and Mental Health Administration—through its research, community service, and construction programs—and the Social Security Administration and Social and Rehabilitation Service—through their medical assistance programs.

The principal interests of the association in the July 1, 1973, administration reorganization of the Health Services and Mental Health Administration are the assignment of the Regional Medical Programs Service and the Health Care Facilities Service to the new Health Resources Administration and the transfer of the Bureau of Health Manpower Education from the National Institutes of Health to the Health Resources Administration. At the same time, the association stresses that while these are its principal interests, its general interest includes all of the reassignments and transfers associated with the reorganization.

In this statement, the association is commenting also as a member of the Federation of Associations of Schools of the Health Professions. The federation was organized in 1968 to bring together health education groups with similar interests for discussion, cooperation, and action on a national level. The various institutions represented by the association members of the Federal are responsible for the education of health professionals in the United States who bear the responsibility for maintaining the health of its citizens.

This statement presents the association's concerns with the reorganization of the Department's health agencies and with the decentralization of Federal health programs administration and the association's recommendations for the organization and administration of Federal health programs.

AAMC CONCERNS WITH REORGANIZATION

The latest reorganization of the health agencies of the DHEW expanded the number of agencies reporting directly to the Assistant Secretary for Health from three to five; abolished the 5-year-old Health Services and Mental Health Administration; reassigned most of its former functions to a new Health Resources Administration or a new Health Services Administration; upgraded the Center for

Disease Control; reassigned the National Institute of Mental Health to the NIH; and transferred the Bureau of Health Manpower Education from the NIH to the Health Resources Administration.

In announcing the reorganization, HEW Secretary Caspar W. Weinberger said:

> I am confident that this restructuring of the agencies reporting to the Assistant Secretary for Health will increase the efficiency and effectiveness of the Department's health programs and facilitate the development of sound policy in this area of our responsibility.

The association agrees with the objectives described by the Secretary. Its concerns arise because it is not clear how those objectives are to be met through the reorganization. The association's concerns involve the seeming concentration on health agency reorganization, for its own sake; the transfer of the health education assistance programs from the NIH; and the omission of medicare and medicaid from the health programs for which the Assistant Secretary is directly responsible.

REORGANIZATION FOR ITS OWN SAKE

While there is widespread agreement among persons in the Federal Government and outside of it that the administration of Federal health programs needs improvement, and that some reorganization probably would help, there appears to be excessive interest in reorganization, merely for its own sake. It sometimes appears as though there was hope that simply shifting boxes on an organization chart might magically result in an optimum arrangements, producing the sought after improvement in health program administration. The various health agencies of the HEW have been organized, transferred, and assigned, and then reorganized, retransferred, and reassigned.

No single arrangement ever seems to have been tested long enough to provide an assessment of its efficiency and effectiveness. It seems unfortunate that now yet another reorganization is underway, with no clear advance indication that it will be any more successful in improving Federal health program administration than any of its predecessors.

TRANSFER OF THE BHME

The Bureau of Health Manpower Education administers the various programs of direct Federal assistance in the undergraduate education of health professionals. As a result, it is the Federal agency most directly related to those activities associated with the teaching function of the medical schools. The inclusion of the Bureau in the National Institutes of Health, whose research institutes and divisions support much of the biomedical research carried out in the medical schools, has seemed an appropriate grouping of related responsibilities.

When you separate the Bureau from the NIH we think it may dismantle some of the synergism which has occurred in the interactions of research and professional education. Dale Wolfle, in a very thoughtful book, "The Home of Science," has pointed out that the strength of American science has come from the fact that it was developed within educational institutions, was closely related to educational programs, and thus provided not only advancement of knowledge, but did strengthen our whole educational program, not only in the health area, but in other areas.

We are concerned that the separation of these two parts into different aspects of the Department may really reduce some of the synergism which we think has been very important in institution building which is the sine qua non of producing good health professional manpower. We are also concerned about the omission of medicare and medicaid from the purview of the Assistant Secretary.

This is the largest segment of the Department's health spending. It is true that some have argued that these programs are to a degree income maintenance programs. At least there are some who hold this view.

We think this is not the case, that these really are major health programs, and that they have an important impact upon the American health care system. For that reason, they should be rightfully included in the framework of other Federal health programs.

For only in this way can there be developed a coherent national policy on health, encompassing the conduct of biomedical research, the education of health personnel, and the delivery and financing of health care.

We would also like to echo many of the things you heard this morning about decentralization. There is a great emphasis in the present administration of the Department in decentralizing the programs of the Department to the regional offices of HEW. You have heard a great deal this morning about some of the problems which Dr. English and Dr. MacLeod saw in this decentralization. We believe that it will be counterproductive to the advancement of health programs; it will fragment the programs into arbitrary segments which will not produce a coherent or national whole; the decentralization of these activities would be a very grave misapplication of sound fundamental principles of the American Government.

We think that by decentralizing these programs, it is going to increase the difficulty of Congress maintaining any sort of oversight of the activities related to legislation that it has passed. In contrast, in the present situation, Congress can get a much better view of the national scene.

We can't understand how they are going to allocate the funds to the various regions, as they propose. The regions are different in size, resources, and needs; and it is going to be a very complex matter to decide how to allocate the funds provided to these regions.

We agree with the statement that Dr. English made this morning that it is going to be very difficult to attract the kind of health professionals into the administration of these programs at the regional levels which will make them effective and efficient.

We have heard, as well as he has, that many of those who have been asked to go to the regional offices will not go; and we stand a chance of losing a lot of the health professionals that have been brought into the Federal Government.

The other great problem is we don't see how many of the programs which, by Congress direction require review, approval, and consideration by national advisory councils, can be administered if these programs are decentralized. There have been some statements in the press—how true they are, I don't know—that in some of the decentralization the delegation of powers by the Secretary to the various regions will in essence preclude the ability of national advisory

councils to give real consideration to the overall program which the Congress has passed.

We think that it is not going to save money. We think the replication and duplication of support services and the whole bureaucracy which is going to be required, is going to cost more money than the present centralized approach. And with each additional layer of bureaucracy you seldom add to an organization's efficiency.

We were also concerned with the opposite side of this coin, and that is centralization of authority in the Office of the Assistant Secretary. As you know, we have testified on a number of occasions for a strong Department of Health and a strong position for the Assistant Secretary of Health. That is not the matter we are concerned about.

However, Dr. Edwards has stated that he is assembling a staff of 936 people in his Office. This represents a major increase over previous staff levels. We do think the Assistant Secretary has to have more staff than his predecessors had, if he is going to carry out his responsibilities to develop a national health strategy, and more importantly, in promoting the cause of health in the decisionmaking apparatus of the executive branch of the Government. So we have no quarrel with this. What we are concerned about is that this is being done in a sense at the expense of the staffing of the various agencies under the Assistant Secretary.

We have, on the one hand, the centralization of staff and authority and responsibility in the Assistant Secretary's Office; and on the other hand, the regionalization of the staff of the agency. So we have a dumbbell-shaped situation where in the middle the staff is not adequate, we believe, to permit these agencies to make their appropriate input to the development of policy and to carry out the functions which are assigned to them.

We are concerned about this, about what appears to be a move to reduce the authority and responsibilities of the various agencies. We are against developing a monolithic centralized administration. We think that the Assistant Secretary's principal task is to orchestrate a very strong group of agencies which can make their contributions in the development of health policy and in carrying out the functions of the Department.

So, we are concerned about centralization as well as decentralization.

Now, what would we recommend? I think we would like to recommend the same things that we have recommended in the past when we have been before your subcommittee.

One is that we find a way to create a Department of Health, and that we give that Department of Health the kind of strength, authority, staffing and so on, which is necessary for it to carry out its functions.

We would like to again repeat our suggestion that we try and get at the very basis of the need for this continual reorganization by having a commission on health programs, one that would look broadly at all of the problems that face us and stop the piecemeal kinds of reorganization. We think that this commission should have representatives from the Congress, executive branch, and public on it.

As we have said in the past, there is precedent for doing this. The Public Land Law Review Commission was established by the Congress in 1964. It required 5 years to study all of the laws and organizations and relationships and administrative rules that relate

to Federal land. Legislation which that Commission recommended is still working its way through Congress. It was an overall coherent review of what the problems are. We would again like to urge that some consideration be given to having a hard look at the organization of the health programs in HEW and that this be participated in by Congress, the executive branch, and the public.

Thank you.

[Dr. Cooper's prepared statement with attachments follow:]

STATEMENT OF DR. A. D. COOPER, PRESIDENT, THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES [1]

Mr. Chairman and members of the subcommittee:

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This statement presents the Association's concerns with the reorganization of the Department's health agencies and with the decentralization of federal health programs' administration and the Association's recommendations for the organization and administration of federal health programs.

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[1] Presented by John A. D. Cooper, M.D., President of the Association of American Medical Colleges, before the Public Health and Environment Subcommittee of the House Committee on Interstate and Foreign Commerce, July 31, 1973.

NIH; and transferred the Bureau of Health Manpower Education from the NIH to the Health Resources Administration. In announcing the reorganization, HEW Secretary Caspar W. Weinberger said: "I am confident that this restructuring of the agencies reporting to the Assistant Secretary for Health will increase the efficiency and effectiveness of the Department's health programs and facilitate the development of sound policy in this area of our responsibility."

The Association agrees with the objectives described by the Secretary. Its concerns arise because it is not clear how those objectives are to be met through the reorganization. The Association's concerns involve the seeming concentration on health-agency reorganization, for its own sake; the transfer of the health education assistance programs from the NIH; and the omission of Medicare and Medicaid from the health programs from which the Assistant Secretary is directly responsible.

Reorganization for its own sake.—While there is wide-spread agreement among persons in the federal government and outside of it that the administration of federal health programs needs improvement, and that some reorganization probably would help, there appears to be excessive interest in reorganization, merely for its own sake. It sometimes appears as though there was hope that simply shifting boxes on an organization chart might magically result in an optimum arrangement, producing the sought-after improvement in health program administration. The various health agencies of the DHEW have been organized, transferred and assigned, and then reorganized, retransferred and reassigned. No single arrangement ever seems to have been tested long enough to provide an assessment of its efficiency and effectiveness. It seems unfortunate that now yet another reorganization is underway, with no clear advance indication that it will be any more successful in improving federal health program administration than any of its predecessors.

Transfer of the BHME.—The Bureau of Health Manpower Education administers the various programs of direct federal assistance in the undergraduate education of health professionals. As a result, it is the federal agency most directly related to those activities associated with the teaching function of the medical schools. The inclusion of the Bureau in the National Institutes of Health, whose research institutes and divisions support much of the biomedical research carried out in the medical schools, has seemed an appropriate grouping of related responsibilities. The synergistic benefits of biomedical research and medical education have elevated American biomedical research to its present world-leading position and have helped to develop some of the world's most imaginative, creative and sensitive physicians. The Association is concerned that separating federal support for biomedical research and federal support for medical education may dismantle this synergistic system with its clear and impressive benefits. Most importantly, such a system, once dismantled, may prove extremely difficult, if not even impossible, to reassemble.

Omission of Medicare and Medicaid.—Since the Medicare and Medicaid programs of medical assistance account for by far the largest segment of the Department's health spending, it is not clear that their exclusion from the organizational framework of the Department's other health agencies will facilitate the development of sound health policy. That is a serious shortcoming, since development of sound health policy is one of the Secretary's objectives in approving the July 1 reorganization. It is true, as some have argued, that these programs to a degree are income maintenance programs rather than health programs. Under that reasoning, their exclusion from the health framework is understandable. It is even more true, however, that the impact of the Medicare and Medicaid dollars on the American health care system is enormous. For that reason, these are health programs, whether one likes it or not. As such, they rightfully should be included in the framework of other federal health programs; for only in that way can there be developed a coherent national policy on health, encompassing the conduct of biomedical research, the education of health personnel and the delivery and financing of health care.

AAMC CONCERNS WITH DECENTRALIZATION

The Association is concerned generally that the increased emphasis on distributing currently centralized administrative authority to DHEW regional offices will produce serious problems in the proper administration of some health programs. There are many activities in which the federal government has acquired a role where the essential decision-making is inherently or predominantly of a state, local or regional nature. Some examples from the field of health include provision

of health personnel to underserved areas, control of certain communicable diseases, and control of drug addiction and alcoholism. The administration of federal efforts in these areas could well be decentralized as one way of making government more responsive to the needs of the people. At the same time, there are many federal programs in which the decision-making process involves matters that transcend state, local or regional interests and clearly are national in nature. Federal support for the education of health professionals and the conduct of biomedical research are useful examples of these kinds of activities. Attempts to decentralize administration of federal assistance in these activities would, the Association believes, be counterproductive, fragmenting into arbitrary segments activities which are intrinsic elements of a coherent, national whole, for which decisions must be made on a national basis. A move to decentralize administration of federal programs related to these activities would be a grave misapplication of a very sound, fundamental principle of American government.

More specifically, the Association's concerns with decentralization include the following:

1. The Congressional authorization of project grants in the field of health manpower education implies national rather than regional competition for the funds. Since health manpower training resources are not distributed evenly on the basis of population or geography, it is difficult to understand the basis on which funds would be allocated among the various regions.

2. The present personnel of the Bureau of Health Manpower Education are highly specialized, professional administrators of extremely sophisticated and complex education assistance programs. It is not clear that the personnel pool of such administrators is large enough to reproduce in the various regional offices the existing professional skills and talent of the central headquarters unit.

3. The very practical problem of logistics—involving travel and communications—seems to be aggravated rather than ameliorated by a plan of decentralization. It is not at all clear how the efficient and effectiveness of the Department's health programs will be improved by fragmenting the decision-making process among the regional offices.

4. In many health programs, Congress has mandated public participation in the decision-making process by requiring review, and in some cases approval, of decisions by national advisory councils. It is unclear how such a national review mechanism is to operate if decision-making authority is assigned to the regional offices. One possible outcome, elimination of the advisory council review process, would thwart a principal objective of decentralization by further removing the decision-making process from the people rather than bringing it closer to them.

5. The various public groups, such as the Association, which are interested in the numerous federal health programs are presently organized on a nationwide basis to provide the federal government with the best information available on the needs of its constituents and to provide their members with the most accurate and complete information on government activities. These groups serve a useful role in the development of federal health programs and policies. It is not clear how such a role would be continued under a plan to decentralize administration of the programs.

6. The increased cost of replicating across the country the necessary files, office equipment, supplies, administrative support services and so forth appears to be a serious drawback to decentralization. How such cost increases relate to the hoped-for increased efficiency is very unclear.

7. The increased authority which would be assigned to the various regional offices under decentralization would seem to increase rather than decrease the levels of bureaucracy through which an application for assistance or a decision for action would have to pass. Each additional level of bureaucracy seldom adds to an organization's efficiency. In fact, each bureaucratic level seems to generate its own additional inefficiency.

8. Central determination of program policies has the unquestionable advantage of uniform policy formulation. Decentralized administration of these programs increases the possibility of significant variations in the interpretation of national policy by the various regional offices. It is far from clear that given the sensitivity of many of the issues associated with federal health programs, it would be desirable for regional preferences or biases to predominate.

AAMC RECOMMENDATIONS

The Association of American Medical Colleges has long been concerned with the absence of a coherent system of federal health programs. It is a dismaying thought

to realize federal health programs are operated by at least 23 separate departments and agencies and to appreciate that during the Johnson Administration alone some 51 pieces of health legislation were enacted. It is no wonder that as former HEW Secretary Elliot L. Richardson said in the Megaproposal, "We are now in a crisis of complexity, fragmentation and overpromise."

The ultimate solution to the problem of more adequate health care will not be achieved through the enactment of yet another, separate categorical program of federal assistance or through yet another reorganization of federal health agencies. The ultimate solution requires the development of a clear, coherent, and comprehensive national health policy supported by stable financing. This policy should set forth the objectives to be sought, delineate the public and private roles, and provide the program strategy that will assure the availability of effective health services to all the people of the nation.

Without a coherent and comprehensive program strategy and a clear assignment of responsibility, neither a new set of national goals nor a new financing mechanism, alone, will solve the widely acknowledged problems of uneven distribution of health care personnel and resources, both in terms of geographic location and in terms of medical specialty; the ineffective utilization of physicians, nurses and other health personnel; the overemphasis on treatment of sickness rather than on maintenance of health; and the counterproductive fragmentation of health care, symptomized in separate and competing services for veterans, the military, the elderly, the poor, the blind, and so on. A direct confrontation of these problems in implementing a national health policy is essential to their resolution.

In the Association's view, two steps must be taken:

1. Establishment of a separate, Cabinet-level Department of Health; and
2. Establishment of a National Advisory Commission on Health Programs to undertake a comprehensive study of all health programs of the DHEW and to recommend appropriate restructuring of those programs for maximum efficiency in meeting the health needs of the nation.

Department of Health.—The present framework within the DHEW subordinates and submerges the health function in a manner which derogates the critical significance of these vitally important programs. There needs to be a single, authoritative point of responsibility for health policy within the federal structure. There needs to be a vigorous national leadership for the evolution of sound federal programs in the health field. The Association believes that the best way of meeting these needs is the establishment of a separate, Cabinet-level Department of Health. As recently as May 1972, the Association's Executive Council adopted a resolution supporting such a move. The text of the resolution said:

> Therefore be it resolved that the Association of American Medical Colleges wholeheartedly supports the establishment of a Cabinet-level Department of Health to serve as the single point of responsibility for defining health policy, administering federal health programs and evaluating the state of the nation's health. The Department should be administered by a Secretary of Health appointed by the President with the advice and consent of the Senate. The Secretary should be responsible for all health programs now administered by the Secretary of Health, Education and Welfare, including Medicare and Medicaid and any new program of national health insurance. In connection with the establishment of a new Department of Health, an independent panel of experts should conduct a study to develop a thoughtful and coordinated national health policy and a detailed national health program for meeting current and future health needs for the United States.

Those views still represent the position of the Association.

Commission on health programs.—Already there are Congressional efforts underway to recodify the Public Health Service Act and related health laws and to restructure the legislative authorities for federal health programs. To give this restructuring the broadest base possible and the best advice available, the Association recommends that Congress establish a National Advisory Commission on Health Programs.

The goal of the Commission would be to determine the proper federal role in the nation's health. It would clarify that role, discover what legislation is needed, define the proper organization, and establish national priorities in health. No lesser goal would lead to the development of a coherent national health policy.

It would be necessary for the Commission to have a broad political representation in order to meet the wishes and requirements of both the Congress and the executive branch. It might be composed about equally of Members of Congress and members appointed by the President. Of the latter members, no more than half should be directly involved in the organization or provision of health services.

Representation should include members of both political parties. Guidance for its composition might be found in legislation that established the Commission on Marihuana and Drug Abuse.

The Commission would meet regularly, but its staff would be at work on the project full time. It should be empowered and funded to hire whatever employees and consultants may be required to conduct detailed studies of health programs. The Commission should be given sufficient time, probably two years, to report its findings and to make its recommendations to the Congress. The specific responsibilities of the Commission would be defined by statute.

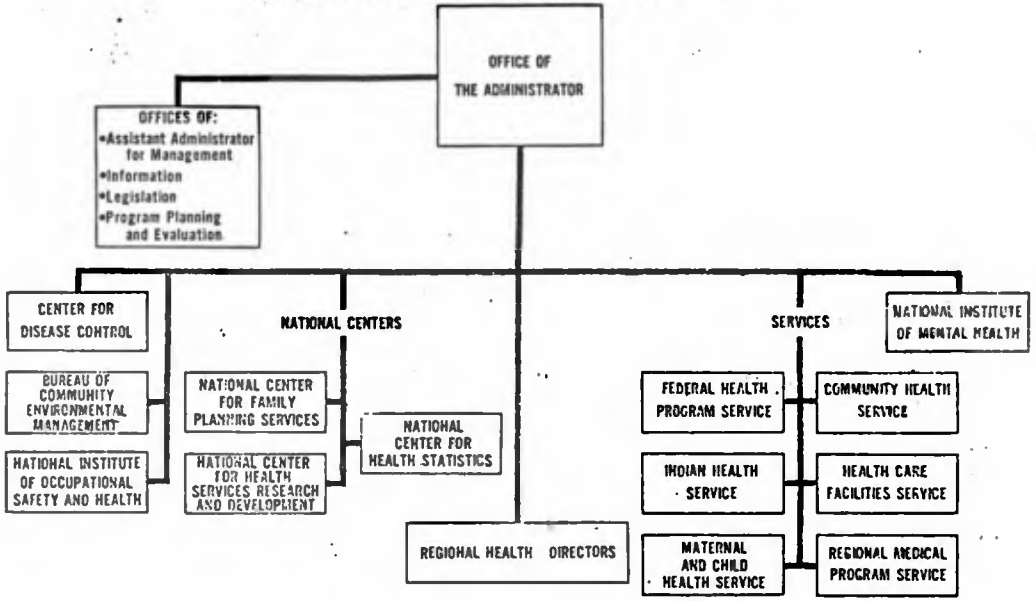
There are precedents for advisory commissions of this magnitude. The Public Land Law Review Commission, established by Congress in 1964, required five years to study 4,400 public land laws and tens of thousands of administrative rules governing nearly 725 million acres of federal land. Legislation recommended by that Commission is still making its way through Congress.

The Public Health Service Act, for all its complexity, would not present so formidable a task. But the Act and health programs that come under other federal health laws should be studied just as rigorously. The Commission should be free to recommend, with the expectation of Congressional support, whatever measures may be necessary to define the federal role and to improve federal health programs.

Following this page are tables of organization showing the former Health Services and Mental Health Administration and the effect of the July 1, 1973, administrative reorganization on the HSMHA.

Department of Health, Education, and Welfare

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION



EFFECT OF JULY 1, 1973, REORGANIZATION ON THE HSMHA

CENTER FOR DISEASE CONTROL

Office of Director

National Institute for Occupational Safety and Health.—(All of the presently assigned functions).

Bureau of Epidemiology.—Epidemiology Program.

Bureau of Laboratories.—Laboratory Division.

Bureau of State Services.—State and Community Services Division; Bureau of Community Environmental Management (only lead-based paint poisoning, rat control, and the Arctic Health Services Research Center functions).

Smallpox Eradication Program.—(All of the presently assigned functions).

Training Program.—(All of the presently assigned functions).

Tropical Disease Program.—Malaria Program.

National Clearinghouse for Smoking and Health.—(All of the presently assigned functions).

Ecological Investigations Program.—(All of the presently assigned functions).

HEALTH RESOURCES ADMINISTRATION

Office of the Administrator

National Center for Health Statistics.—National Center for Health Statistics.

Bureau of Health Services Research and Evaluation.—National Center for Health Services Research and Development; Regional Medical Programs Service.

Bureau of Health Resources Development.—Bureau of Health Manpower Education; Comprehensive Health Planning Service Health Care Facilities Service; Office of Long-Term Care Services.

HEALTH SERVICES ADMINISTRATION

Office of the Administrator

Indian Health Service.—(All of the presently assigned functions).

Federal Health Programs Service.—(All of the presently assigned functions).

Bureau of Community Health Services.—National Center for Family Planning Service; Maternal and Child Health Service; Community Health Service (except for the Office of Long-Term Care Services and the Division of Medical Care Standards); National Health Service Corps; Health Maintenance Organization Service.

Bureau of Quality Assurance.—Division of Medical Care Standards.

Mr. ROGERS. Thank you very much. I think those suggestions are helpful. I am sure the committee will give them serious consideration. I think you know that most of the committee members share your feeling about a separate Department of Health. I would hope all of us feel this needs to be done to coordinate efforts so that this can become a reality, at least by next year. Thank you so much.

What is the pleasure of the panel? Who would like to be next?

STATEMENT OF EILEEN M. JACOBI

Mrs. JACOBI. I am Eileen Jacobi, executive director of the American Nurses' Association. I would like to commend the subcommittee for scheduling these hearings which provide an opportunity for health groups to express concerns which they have about the reorganization of the health component of the Department of Health, Education, and Welfare.

We fully recognize the right of administrators to revise organizational plans to promote more effective operations. In this instance, however, we have serious reservations about the long-range effects which this reorganization will have on programing, effective use of resources, and the eventual impact in terms of improved health programs.

Regionalization or decentralization as a concept has been effective for those programs in which specially qualified staffs have been moved to the regions to increase the contacts of specialists in the professional areas with people desiring their expert guidance and consultation.

We question the current move for decentralization because it seems to decmphasize content areas; staff being sent to regions appear to be chiefly those working with technical or grants management aspects of programs. Apparently there is no plan to have experts—for example, experts in the field of nursing education to implement the Nurse Training Act programs in each region.

A basic concern of ANA, and I assume of HEW, is that there be the most effective use of Federal funds.

Those activities for which Congress has indicated a national program such as project grants and short-term training programs for nursing, certain maternal and child health and mental health programs, certainly deserve staffing by competent content experts. If decentralization is to be effective, we urge that specialists for each program be located in each regional office. We fear that health manpower programs will be grouped and that one or two representatives of the various disciplines will make all the decisions at the regional level. For example, we think that physicians should not guide the use of nursing funds nor should nurses guide funds for medical or dental schools. Expert consultation in the planning phase of projects has been a most effective part of HEW programs in the past.

The integrity of the grant application review process also is threatened under decentralization. A standard review system carried out by peers provides for equity. This could be jeopardized as a result of the differing interpretations of health manpower policies and priorities in each of the 10 regions and the growing tendency to have HEW staff review, recommend funding or not, and monitor projects once funded. To safeguard the system it will be even more essential for Congress to write into legislation grant review by outside statutory bodies.

There must also be a coordination of national programs through a headquarters office. Regional staff need to relate to policy planners at the top, and this we think can be done only if strong central offices are maintained with direct administrative line authority. The Division of Nursing, we believe, has a vital role to play in coordination, planning, and evaluation of nursing programs. The interrelationship of education, research, and service considerations and the projection of nursing needs should be coordinated in an administrative structure at the national level. You probably noticed that on page 50 of the House Appropriations Committee Report—H.R. 8877—spoke to the concerns about a national Federal focus for nursing. We hope HEW will carry out the wishes of the Congress. However, as yet it is considered an unresolved issue.

Much progress in nursing and in nursing education has been attributable to the services, research, and coordination provided by the Division of Nursing. This progress, in turn, has been to the benefit of improved health care. We think that it would be detrimental to the interests of good health care if this focus were to be lost or diminished in the reorganizational juggling that is now going on.

In the maternal child health area, as in several others, we urge you to carefully review the ever-changing administrative charts. You will notice at once the low placement on the charts of content specialists of all disciplines. The lines are somewhat unclear, as it is said they can go in several directions. The professional staff of the maternal child programs are scattered throughout. This, in our opinion, will weaken the programs and will create unnecessarily complicated program development. The move to deemphasize the role of health professionals by replacing them in policy positions with nonhealth personnel has been very evident for the past 4 or 5 years. In the Maternal and Child Health training unit, for example, there are to be no health professionals. Therefore, program decisions about the use of millions of health dollars are being made by businessmen, systems analysts, and economists.

While there is a place for this kind of expertise, care must be taken to maintain a proper balance to assure that professional considerations about health care are safeguarded. This is essential to develop and maintain effective health programs. The lack of really effective evaluation of the programs carried out by HEW lately has been noticed by many groups, including this committee.

There are numerous other questions about reorganization and decentralization that are as yet unanswered. One important one that we would just like to raise is in relation to cost. With the duplications that seem almost inevitable with programs administered in 10 regions instead of centrally, we think that the cost factor is one that should be carefully investigated. One question we have yet to hear answered is what is the total cost of the reorganization going to be? Also, the cost of decentralization is not spelled out. How many health professional positions are to be eliminated and what are the long term budget considerations of this change in structure? We hope this committee will get answers to these questions before it is too late.

I would like to thank you for holding these hearings on this important topic at this time, and I appreciate the opportunity to appear here today.

Mr. ROGERS. Thank you, Dr. Jacobi. We appreciate the points you raised and will try to find out the answers to some of these questions which I think are important to know before we move into that kind of a change. Thank you so much.

Dr. Roy?

Mr. ROY. I thank you for your statement and apologize for being a bit late. I have no questions at this time.

Mr. ROGERS. Dr. Kerr?

STATEMENT OF DR. I. LAWRENCE KERR

Dr. KERR. Thank you, Mr. Chairman, for allowing us the opportunity to participate in these hearings and I would say we echo much of what has been said earlier.

My name is Dr. I. Lawrence Kerr and I am appearing today on behalf of the American Dental Association. In addition to my responsibilities as a trustee of the American Dental Association, I also had the honor to serve as chairman of the Advisory Committee on Dental Health to the Secretary of Health, Education, and Welfare.

This committee was established in 1970 to review the dental health programs of the Department and suggest ways in which they could be improved. Our activities were concluded in December 1972, with the submission to the Secretary of the Advisory Committee's final report and recommendations. Although we were privileged to meet with Secretary Weinberger since that date, we have received no formal response to these findings. I believe that Congress, my colleagues on the advisory committee and, most importantly, the taxpayer, deserve a statement from the Department.

Yesterday we were presented with the latest program alinements for Health, Education, and Welfare. Unfortunately, nothing in this announced reorganization plan of the Department suggests that the conclusions and recommenations of the Dental Advisory Committee report have been considered.

Briefly summarized, our advisory report indicated that the department's goals for dental health are ill-defined; the administrative structure for dental programs is not coordinated and generally buried so far below the policymaking level that its voice is not heard at the top; and finally, the financial resources allocated to dental activities are inadequate.

We might illustrate that by saying that dental disease is a universal disease. That is, 100 percent of the people have some form of dental disease. Yet dental activities in HEW were 3 percent in 1960 and has been decreased to 2 percent in 1971.

This critique embodies no new facts. The situation described existed many years before the advisory committee's report and still exists today. Individuals and organizations in and out of government have long recognized the problem. Three years ago, the Secretary of Health, Education, and Welfare told Congress that he was ". . . shocked to find after coming into office that we have not really had a national dental health policy." Indeed, the advisory committee was established in recognition of these deficiencies. Its central task was to develop ways in which order could be introduced in the department's dental activities.

It is interesting to note an observation from the advisory committee's 1972 report. "So far as dental health is concerned," the report stated, "reorganization and program integration has all too often meant the submerging of legitimate dental interests and the exclusion of dental health experts from policy decisions."

The accuracy of this prediction is reflected in the current reorganization proposal, as well as the repeated efforts of the Department to remove the budget visibility of the Division of Dental Health; the exclusion of dentistry from the administration's research training plan; a lack of any dental participation in the development and administration of PSRO's for medicare/medicaid; the absence of dentistry from the administration's previous national health insurance proposal; and the fact that the statutory position of the Chief Dental Officer has remained unfilled since 1967.

Our association believes that dental health is an integral and essential part of total health. As the principal agency in making this concept a reality, the Department of Health, Education, and Welfare must recognize and include dentistry at the decisionmaking and policy levels. Full implementation of the recommendations outlined in the Dental Advisory Committee report would be a notable first

step. Where dental activities have a measure of visibility, as within the National Institutes of Health, they must be strengthened. We are completely opposed to the dismemberment of any of these existing components. Our concern is shared by the House Appropriations Committee which recently stated, in part:

> The Division of Dental Health is the only agency in the Department, except the National Institute of Dental Research, that has identifiable responsibilities in dental health . . . Over the years, the Division has conducted a broad range of programs that have had a positive impact on improving the oral health of Americans. This success is in large measure the result of placing the responsibility for these dental activities in a single organizational unit—the Division of Dental Health . . . The Committee believes that these Divisions should be retained and strengthened as a focal point for these important programs if the Department is to meet its responsibilities in these areas.

In those areas where there is little dental input, as is generally true within the health delivery programs, and the Office of the Assistant Secretary for Health, we recommend an administrative structure able to guide and monitor dental activities; the placement of qualified dental personnel in positions of responsibility; a strong statutory advisory committee, and, sufficient financial resources to insure viable dental programs.

In conclusion, I would like to provide copies of the advisory committee's report for the information of this subcommittee. And, again, we thank you for the opportunity of sharing this time with you.

Mr. ROGERS. Thank you very much, Dr. Kerr. We appreciate your presentation and without objection the report you referred to will be received and made part of the record. We will try to get a response from the Department on that report.

[Testimony resumes on p. 189.]

[The report referred to follows:]

REPORT AND RECOMMENDATIONS

TO THE SECRETARY

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

FROM THE

ADVISORY COMMITTEE ON DENTAL HEALTH

December, 1972

LETTER OF TRANSMITTAL

December 29, 1972

Honorable Elliot Richardson
Secretary
Department of Health, Education, and Welfare
Washington, D.C. 20201

Dear Mr. Secretary:

I am pleased to transmit herewith the final report of the Advisory Committee on Dental Health.

Since early 1971, we have learned much about dental health activities within the Department and, as we conclude our work, we are both pleased and disheartened. The Department has several fine dental program elements but as a whole dental activities are underfunded and suffer from a long-standing lack of attention at the highest policy-making and planning levels within the Department.

We believe that corrective action is essential and that adoption of the recommendations which were developed from the Committee's deliberations would do much to strengthen the Department's capacity to deal effectively with the Nation's dental health problem.

Serving on the Committee has been a pleasure. It is our earnest hope that what we have done will be of value to you.

Respectfully submitted.

I. Lawrence Kerr, D.D.S.
Chairman
Advisory Committee on Dental Health

CONTENTS

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(January, 1971 –)
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Executive Secretary: Mr. Melvin L. Dollar

PREFACE

At a meeting held on April 8, 1969, officers of the American Dental Association urged Robert H. Finch, then Secretary of Health, Education, and Welfare, to establish an advisory committee to study the Department's dental health programs and suggest ways in which they could be improved. Mr. Finch agreed that such a committee was in order and directed that preparatory staff work be undertaken.

On July 9, 1970, the Advisory Committee on Dental Health to the Secretary was formally established by Elliot L. Richardson, Mr. Finch's successor. The formal statement of determination, which he approved to establish the Committee, described its purpose and functions as follows:

Purpose

To advise the Secretary on dental health programs and priorities in prevention, education, research and service; on organizational arrangements and administrative mechanisms for achieving maximum coordination and effectiveness of dental health activities within DHEW; and on mechanisms for promoting interdepartmental cooperation in the development and operation of programs to improve the dental health of the public.

Functions

The Committee will address itself first to the identification of appropriate long and short range goals in dental health for DHEW and to the setting of dental health priorities between and within the areas of prevention, education, research and service. It will then review all dental health activities currently supported by appropriations to the Department. This examination will cover past and current goals, activities, program effectiveness, and the possible effects of past and current organizational structure on program operations. With this review as a background, the Committee will consider the organizational structure, administrative mechanisms, and program modifications which DHEW might adopt to achieve the proposed goals in the most efficient and effective manner. Subsequent work of the Committee will focus on issues related to the strengthening of interdepartmental working relationships on dental health matters, particularly with programs for which the DHEW has consultative responsibilities and programs which are highly relevant to DHEW areas of responsibility, and on issues of national importance which tend to limit the availability of high quality preventive and restorative dental services for all segments of the public.*

*During the early months of its deliberations, the Committee gave special emphasis to the study of dental care as part of national health insurance. This was done at the particular request of Department officials. Accordingly, in the remaining months, time constraints precluded fulfillment of all of the functions assigned to it.

Seventeen members of the Committee were appointed as of September 1, 1970, and they held an initial meeting on October 29-30 under the chairmanship of Dr. John S. Zapp, then Special Assistant for Dental Affairs to the Assistant Secretary for Health and Scientific Affairs.

The remaining eight members of the Committee were named as of February 1, 1971, and the first meeting of the full Committee came on February 4-5.

Because of the press of his new duties as Deputy Assistant Secretary for Legislation, Dr. Zapp appointed Dr. I. Lawrence Kerr to succeed him as Chairman of the Committee.

During the course of its deliberations, the Committee had occasion to call upon various Departmental agencies and staff members for assistance, without which it would have been impossible for its work to proceed. Help was given unfailingly, and the Committee is most grateful to all who worked with it. The report and its recommendations, of course, are solely those of the Committee itself.

RECOMMENDATIONS*
OF THE SECRETARY'S ADVISORY COMMITTEE ON DENTAL HEALTH

The Advisory Committee adopted the guiding principle that every person in the Nation should have access to whatever dental health services he may require and that such services are an essential part of total health care. It is also of the opinion that the Secretary of HEW has a responsibility to use all appropriate means to make this right a reality. Accordingly, the Committee respectfully submits the following recommendations, elaborated on in the text, which it believes must be implemented if the Department is to fulfill its dental responsibilities.

PROGRAM RECOMMENDATIONS

I. The Department should squarely face the fact that the human suffering and disability resulting from oral and dental disease is of staggering proportions; it should acknowledge by adoption of appropriate policies that dental care is an essential part of total health care and that every person has the right of access to necessary dental services; and it should establish national dental health goals and formulate a plan and programs essential to their achievement.
(See page 19)

II. The dental manpower programs of the Department should be improved by increased efforts to graduate more dentists and auxiliaries; to overcome problems of maldistribution; to improve educational programs; to achieve greater efficiency in the delivery of dental services through the full use of dental auxiliaries; and to recruit more members of minority groups and more women into the dental work-force.
(See page 20)

III. A grant-in-aid program should be established to provide support for the purchase and installation of fluoridation equipment and for surveillance of fluoridation programs. An intensive nationwide health education program also should be initiated to make the public aware of what can be done to prevent and control dental diseases.
(See page 22)

IV. There should be continued emphasis on targeted biomedical research to expedite the development of new and more effective preventive measures.
(See page 23)

V. A major effort should be launched immediately to conduct a coordinated program of research and development related to the organization, financing, delivery and utilization of dental services, and adequate funds for this purpose should be made available to the Division of Dental Health.
(See page 23)

*N.B The recommendations are listed in the order in which they appear in the report, not in the order of priority

VI. The Department should propose and support a national health insurance proposal that includes at the outset a dental component that gives priority to preventive and therapeutic services for children and emergency dental care for all.
(See page 25)

VII. Departmental dental efforts should give priority attention to the prevention and control of dental diseases of children at least up through secondary school age. Emphasis should be placed on exploring the achievement of these goals within the framework of school-based programs. Accordingly, the Secretary should appoint a combined governmental and non-governmental task force whose charge would include, but not be limited to, the study and evaluation of all aspects of a school-based children's dental care program, and the making of appropriate recommendations thereupon.
(See page 26)

VIII. High priority attention should be given to developing mechanisms assuring the availability of high-quality dental services to minorities, low-income persons and other population groups having special needs.
(See page 28)

ORGANIZATIONAL RECOMMENDATIONS

IX. Establish a Deputy Assistant Secretary for Dental Affairs in the Office of the Assistant Secretary for Health.
(See page 32)

X. Establish a Deputy Administrator for Dental Affairs in the Office of the HSMHA Administrator.
(See page 32)

XI. Establish a Committee on Dental Health as a permanent advisory body to the Secretary.
(See page 33)

XII. Retain the organization placement of the National Institute of Dental Research.
(See page 33)

XIII. Retain the organizational location of the Division of Dental Health with all its existing program components in the Bureau of Health Manpower Education.
(See page 33)

SUMMARY

"I was somewhat shocked to find after coming into office that we have not really had a national dental health policy . . ."

That is what Robert H. Finch told the House Subcommittee on Labor and HEW Appropriations on April 21, 1969, some three months after he had become Secretary of Health, Education, and Welfare.

"Why? This worries me," was the response of Subcommittee Chairman Daniel J. Flood.

The basic thrust of this Committee's report is to endorse the evident accuracy of Mr. Finch's contention and to echo the concern expressed by Mr. Flood. It is this state of affairs that has led to the Committee's recommendations, which are the key items of this report.

The situation to which Mr. Finch referred existed many years before his statement was made and still prevails today. It has crippled the Department's cooperative participation in national dental health efforts, decreased sharply the Department's leadership potential and consistently hampered Departmental attempts to use its dental health funds in an efficient manner. It is a serious failing that can and must be remedied. The aforementioned recommendations are, in the Committee's view, essential elements of any lasting remedy.

Successful programs–in the health field or elsewhere–achieve success by meeting four minimum criteria: a policy framework that clearly defines the problems to be solved; an administrative structure able to guide and monitor progress; expert personnel; and sufficient financial resources.

The Department's dental health activities have traditionally failed to meet those four criteria. Departmental goals in dental health are ill-defined. The administrative structure is unbalanced, insufficiently coordinated and generally buried so far below the policy-making level that its voice is not heard by those at the top. The financial resources allocated to dental public health and dental care activities have always been skimpy and there seems to be no upward trend in sight. Dental research and dental education, it is true, have fared relatively better. One of the few bright spots in the situation is that the Department does have a significant number of well-qualified and highly-motivated dental health experts.

This thumb-nail critique of Departmental dental health activities embodies no new facts. Individuals and organizations in and out of government have long recognized this to be true. Indeed, this Advisory Committee on Dental Health to the Secretary was established because of it. Its central task was to suggest ways in which better order can be introduced into the Department's dental health activities. In reaching its conclusions and forming its recommendations, the Committee has been mindful of the fact that the Department's dental health activities cannot be conducted in a vacuum. They must bear a meaningful relationship both to dental health activities carried out by other private and public agencies as well as to the total health programming of the Department itself. Some brief comments about these relationships are in order.

Americans, like all people, suffer from a massive prevalence of dental disease. Appendix I includes some statistical documentation of the extent of that burden. They are statistics that the Committee fully expects may be thoroughly familiar to health professionals but will shock those of the general public who may read this report.

The very familiarity of dental disease on the personal level--coupled with its generally non-fatal character--gives rise to a fatalistic attitude on the part of some. This, in turn, leads to lethargy about launching new initiatives to lift a burden with which we have lived so many decades.

Put bluntly, too many of us seem to see dental disease as too intractable and insufficiently life-threatening to deserve serious, sustained attention. Moreover, the lack of public knowledge that the bulk of dental disease is avoidable compounds the problem of effective action.

There is, as well, an additional negative factor: the potential cost of really doing something about dental disease. Most current estimates are that barely half the country's population even sees a dentist annually. Far fewer receive continuing dental care of the type and with a frequency that approaches the desirable. Even so, some $5 billion is being spent now each year for dental care. If the Nation would undertake--by a combination of public and private resources--to guarantee regular, comprehensive care to every citizen, the additional, short-run costs would easily run the total to many billions more. However, in view of the preventive nature of dental care, such an undertaking might result in long-term financial savings.

Obviously, not everything can be accomplished at once, the course we Americans generally prefer. The resulting tendency has been to walk away from the problem rather than face the hard choices inherent in determining priorities.

The malaise resulting from this combination of factors is not unique to the Department. It can be readily seen in the disgraceful inattention paid dental disease by state and local health departments. It levies its toll, as well, on the way in which private dental practice is so occupied with meeting the acute needs of a relatively small segment of the population. And it undoubtedly colors the personal attitude of many individuals with respect to the efforts they make, or fail to make, to improve their oral health.

It is the nature of this report that its recommendations focus on the Department's shortcomings both internally and with respect to the leadership role it could assume nationally. This concentration implies no belief that only the Department needs to institute appropriate changes in its philosophy and programming. Parallel changes are required by state and local public agencies as well as within the private sector. If it would, though, the Department could provide both models for the desired changes elsewhere and substantial support to those trying to achieve them.

The Department, at the same time, must relate its dental health programs to the total health activities for which it has responsibility.

Over the years, there has been considerable variation in the way in which policy-makers have addressed themselves to the problems of coordination that invariably exist within an agency of such broad scope as the Department. So far as we are aware, no one would yet

claim that these problems have been totally resolved. In addition, the fluctuations in approach have themselves given rise to some administrative anomalies whose existence hinders optimum operating efficiency. These problems–especially the unduly narrow authority over health programs possessed by the Assistant Secretary for Health–complicate proper administration of dental health activities.

Certainly, dental health programming is presently laboring under severe administrative handicaps. There has been apparent wavering over the years as to whether dental health programs ought to be brought together into a single agency, irrespective of the type of activity being conducted, or whether all dental health programs should be placed within those agencies of the National Institutes of Health and the Health Services and Mental Health Administration to which they seem most appropriate.

The Committee conclusion, as the recommendations make evident, accepts neither of these alternatives. A separate agency encompassing all dental activities runs counter to the currently prevailing philosophy of greater programmatic integration and thus raises pragmatic problems. Beyond that, there is much substance in the opinion that since dental health is an integral and essential part of total health, intimate partnership on the administrative level is essential.

The Committee, on the other hand, is flatly opposed to the dismemberment of such modest dental health components as now exist: especially the Division of Dental Health.

So far as dental health is concerned, integration in the name of better administration has too often in the past meant the submerging of legitimate dental interests, the foreclosing of effective participation in policymaking and planning by dental health experts and fiscal starvation of dental health activities. This latter path is the one that, just in recent years, has led to such unsatisfactory occurrences as exclusion of any dental health provisions in the Administration's national health insurance proposal; the Department's twice-repeated attempt–rebuffed both times by Congress–to remove the budget visibility of the Division of Dental Health; the decline in the percentage of Departmental health funds allocated to dental activities from 3 percent in 1960 to barely 1.6 percent in 1971; and the thoroughly inadequate implementation of the programs established in 1967 under Title V of the Social Security Act to launch dental care projects for needy children.

The Committee's recommendations, then, pursue a middle path. Where dental health activities already have some place in the structure–as is true within the National Institutes of Health–the intent is to strengthen them. Where there is presently a void–as is true generally both within the Health Services and Mental Health Administration and within the Office of the Assistant Secretary for Health–the intent is to begin to fill the void.

In addition to programmatic and administrative recommendations, the Committee is including as Appendix II a series of recommendations previously submitted to the Secretary. These include statements on dental benefits in publicly-funded programs.

It is the Committee's deeply felt conclusion that the prevalence of dental disease is not literally intractable. In fact, just the opposite is true if early and proper attention is provided. The level of dental technology is high; the scientific base is impressively broad and deep; and public and private organizations are already available. Something substantial can be done if the Nation and the Department will give the problem the serious, sustained attention it deserves.

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The Department is a key agency in the effort toward swifter and more genuine progress in dental health. It has the fiscal resources and the dedicated personnel sufficient to play a far more positive role than it has ever done heretofore. The Nation will be well served if the Department will now harness its energy and money to a well-considered, long-term plan of action on dental disease. Full implementation of all the recommendations that appear in this report would be a notably important first step for the Department to take.

CURRENT DENTAL ACTIVITIES OF THE DEPARTMENT

Programs within the Federal Government that bear directly on dental health research, education and service were found by the Committee to be vast in number and complex in substance. Beeause of the administrative disarray, it was a formidable challenge to achieve a thorough understanding of them together with their interrelationships, strengths, weaknesses, voids or overlaps.

During the course of the Committee's deliberations, a number of presentations were made by program officials of the Department. Materials were provided describing dental health related programs in the Federal Government and, for some programs, their legal bases and their budgets. Though subsequent changes in legislation, organization or appropriations have invalidated some specifics of the presentations and materials, the situation they describe basically still obtains: complexity, diffusion, and proportionately small budgets.

The number of programs of the Federal Government having dental-related components can best be seen in the document entitled "Dental Health Related Programs in Federal Agencies."[1] In FY 1970, the base year of the report, five Federal departments and two independent agencies were engaged in dental activities. (See Appendix III for main legislative authorizations under which the programs operate).

Within HEW alone, all of the agencies were engaged in dental activities, though only the National Institutes of Health had programs which were exclusively dental.

In FY 1971, Departmental expenditures for dental programs approximated $235 million or 1.6 percent of the Department's $15 billion health budget. This is a steep and unacceptable decline in the percentage of health funds allocated to dental activities, which were 3 percent of the total in 1960.

These dental funds were distributed as shown in Figure 1: Service, 56 percent, Manpower and Education, 29 percent, and Research, 15 percent. Descriptions of the major programs in each of these categories follow.

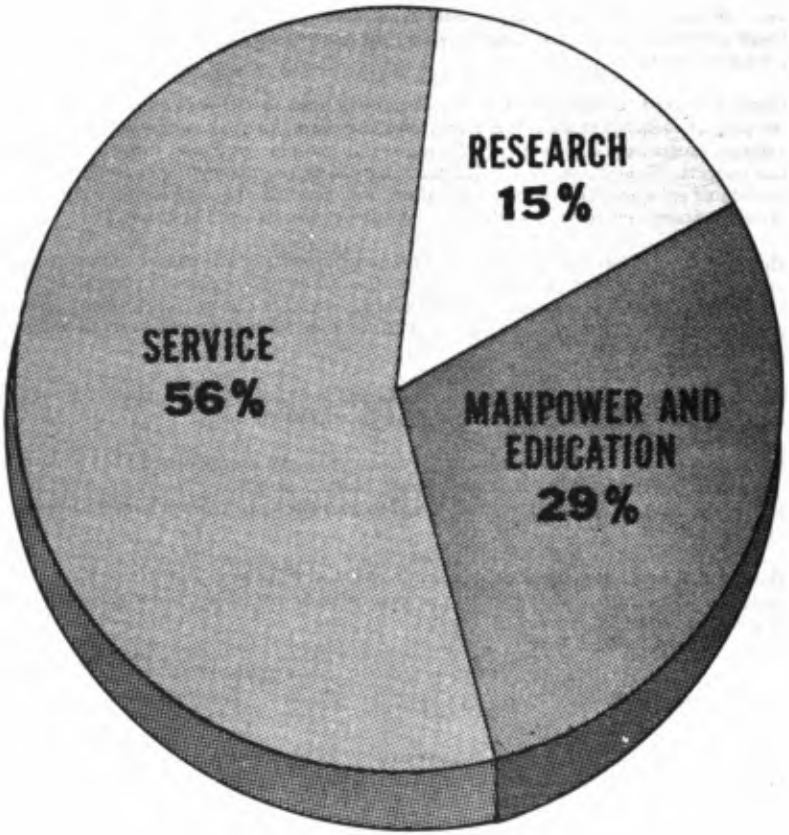
SERVICE

More than twenty programs in the Department are involved in dental service activities. Altogether, it is estimated, based on information obtained in July, 1971, that they spent $130 million in both FY 1971 and 1972, roughly nine times the amount spent in FY 1960. However, this dental total represents less than 1 percent of the total health services budget for FY 1972. By contrast, some 9 percent of all private health service expenditures are devoted to the purchase of dental services.

HEALTH AGENCY PROGRAMS

Dental care programs: The direct care responsibilities of the Department are lodged in the Indian Health Service and the Federal Health Programs Service of HSMHA. Both provide

DHEW Dental Dollar



$235 MILLION

FIGURE I

dental care to eligible beneficiaries.

One of the most significant accomplishments of the direct care programs has been achieved by the Indian Health Service in its program for children. As of 1970, in many schools, children in every grade above the first were on a maintenance basis. About 70 percent of all school children were actually receiving dental care--a much higher rate than that found in the general school population today. This is accomplished, however, by placing a high priority on children and a consequent, relative down-grading of services for the adult members of this beneficiary group.

In terms of dollars spent, the Indian Health Service dental program has grown from about $1.9 million in 1960 to approximately $6.8 million in 1972. The dental portion represents 4.8 percent of the total Indian Health budget, an increase of 0.6 percent since 1960.

The dental program of the Federal Health Programs Service--which includes such categories of beneficiaries as the Merchant Marine, the Coast Guard, the PHS Commissioned Corps and the Federal Prison system--has not fared so well. Its budget has increased by 50 percent over the last decade to stand at $6.1 million; however, this represents a smaller share of the total budget than in earlier years.

Support for direct care projects: Six programs within HSMHA finance the provision of dental services through project grants. Three are administered by the Community Health Service and three by the Maternal and Child Health Service. All of these programs were initiated within the last ten years. Altogether, it is estimated that they spent more than $15 million on dental services in FY 1972, about 6.2 percent of their total budget.

The Health Services Development Grants Program of the Community Health Service is the largest of these programs. It was expected to spend at least $6.3 million in FY 1972, principally on the dental components of comprehensive health centers. Of 34 such comprehensive health centers, 21 provide no dental services whatever. Of the 13 that do provide such services, the program is often minimal in range. Dental services costs account for 4.8 percent of the total budgets for projects funded under this program.

The Health Services Development Grants Program also supports 11 service projects that are wholly dental. One is an incremental program for children in a large metropolitan area. Several others are developing community services for the chronically ill and aged and for other homebound people.

The Community Health Service also administers the Migrant Health Program. About three-fourths of the projects supported by this program included some dental care among the range of health services provided for migrant and seasonal farmworkers and their families. For the most part, the dental services have been limited to emergency procedures necessary for the elimination of pain or infection. The Community Health Service is making a major effort to upgrade these programs. Recent regulations declare that a full range of services are essential to health and establish a system of priorities which gives precedence to the treatment of children. However, this change will have its greatest influence on newly developing programs. Less than 6 percent of the total Migrant Health Program budget for FY 1972 was used to support dental services.

The Appalachian Program, administered by the Community Health Service upon delegation by the Appalachian Regional Commission, includes several large multi-county dental programs among the health activities it supports. An estimated 11.7 percent of its total health services budget for FY 1972 was earmarked for support of these dental projects.

Of the three project grants programs administered by the Maternal and Child Health Service, the oldest is the Maternity and Infant Care Program. About half of the Maternity and Infant Care projects provide dental services, although only a fraction of all expectant mothers receive any dental care. Only about 32,000 women received services in FY 1971, with $1.1 million used for this purpose. This sum represented 2.6 percent of the total budget.

The Children and Youth Program supports dental services in 58 of 60 comprehensive care projects, and, in the remaining two, the project has made arrangements for care to be provided by others. It is the largest of the activities of the Maternal and Child Health Service Program, serving principally the children who reside in the ghettos and inner city areas of metropolitan areas. In FY 1972, an estimated $4.5 million was used for dental services, approximately 9.5 percent of the total program budget. In this program, too, there are wide differences from project to project in both the range of dental services available and the proportion of eligible children actually receiving care.

From a dental standpoint, the potentially most significant Maternal and Child Health Service grants program supports projects specifically aimed at improving the dental health of children. Because of Departmental neglect, however, that potential is largely unrealized. For example, more than two years ago, the House Subcommittee on HEW Appropriations, in its report on fiscal 1970 appropriations for the Department, said it was "concerned about the lack of a coordinated program for the dental health of children while so many federal dollars are being spent under Medicaid and similar programs to treat dental conditions in adults that could have been prevented."

That concern was valid and remains so today Perhaps the best example of the way in which the Department has failed in this regard is the five-year-old law that led to establishment of pilot dental care programs for needy children under Section 510, Title V of the Social Security Act.

This law, passed in December, 1967, possesses features admirably suited to implementation of what we know today about the optimum treatment of dental disease. If the Department had given it even moderate support and funding during its life, it would have yielded by now a number of invaluable results

By now, many hundreds of thousands of children who do not have ready access to preventive care would have been the beneficiaries of the law. By now, a number of model experiments would be well underway, in both rural and urban settings, to discover the best ways of organizing and delivering dental care to groups of children. By now, hard data would be available in large measure to help intelligent planning of national programs of dental care.

Instead, because of the Department's refusal to fund the program adequately, almost nothing has been done for a five-year period Less than $3 million has been allocated in total, relatively few children have benefitted, and no information on methods of delivery and organization has been elicited.

Formula grants: The Maternal and Child Health and the Crippled Children's formula grants were, for several years, virtually the only source of support for the dental activities of state agencies. (A dental grant was the last of the categorical grants to be authorized. It was available to the states for only three years before the Comprehensive Health Services grants replaced the categorical program.) At the present time, approximately $1.9 million–$1.6 million in Maternal and Child Health funds and $300,000 in Crippled Children's funds–are being used to support dental activities. This is less than 2 percent of the funds available. It is not much more than the amount devoted to dental activities in the early Sixties though, since that time, the total formula grant funding has more than tripled.

The Comprehensive Health Services grants now support community activities in about the same amount as the Maternal and Child Health Service formula grants. States also use these funds to meet dental administrative costs. In total, though, only $3.3 million of some $90 million in grants is devoted to dental activities.

Health services research and development: The National Center for Health Services Research and Development, HSMHA, supports many health service projects which have implications for the future provision of dental health services. Since the Center has no professional dental personnel on its staff, consultation for projects in the early states of their development is obtained from the personnel of the Division of Dental Health as the need for it is identified. There is no formal mechanism for assuring dental participation, however, and projects that have potential significance for dentistry often proceed without dental consultation or review. Few projects focus solely on dental service problems. At the present time, less than I percent of the grant funds available for research and development projects is devoted to dental projects.

Dental care research and development activities have been conducted by the Division of Dental Health and its predecessor divisions since the early Fifties. At that time, Division staff undertook a series of group practice and prepayment studies and initiated a program of technical assistance to foster and guide the development of prepaid dental care plans. Dental service corporations have now been formed in 38 states. These, along with a variety of insurance company plans, have expanded prepaid dental coverage from less than a million persons in 1960 to about 15 million in 1972. Ten of these 15 million have been added just since 1966. Within this past year, the Division has regrouped some of its resources to give more emphasis to the problems of dental service organization, financing and delivery.

Prevention and control services: The Division of Dental Health bears the major responsibility for the conduct of service programs concerned with the prevention and control of dental disease. The Division has, for several years, provided consultation, technical assistance, and resource information on fluoridation to state health departments, dental societies and citizen committees.

Some 92 million people–about 57 percent of those on public water supplies–now benefit from controlled water fluoridation Most major cities are fluoridated; the majority of unfluoridated communities have populations of less than 10,000. Seven states (Connecticut, Delaware, Illinois, Michigan, Minnesota, Ohio and South Dakota) have enacted statewide fluoridation laws and many more are working on them.

To reach the 22 percent of the population who are not served by public water systems, the Division encourages the fluoridation of school water supplies and the topical application of fluorides in school and community health programs.

Because of its concern over the need for adequate fluoridation surveillance, the Division cooperates with the Bureau of Water Hygiene, Environmental Protection Agency, in technical and scientific matters related to fluoridation, including the development of surveillance training courses for water treatment operators.

Although periodontal disease is the most destructive of dental diseases among adults, the public is largely unaware of its ramifications and often ignores its symptons until too late. The Division has established the prevention of periodontal disease within the limits of present knowledge as one of its major goals and this year is launching a nationwide campaign, not only to alert people to it but to move them to do something about it–particularly to undertake the personal regimens of oral hygiene practice necessary to prevent and control the disease. The campaign will utilize TV, radio and newspapers. It will also include publications aimed at different age segments. In at least one demonstration program, all methods will be brought together in an intense community-wide dental health education program.

Technical support: The Community Health Service provides technical consultation and advice to a variety of private and public organizations, including state health departments and Medicare agencies, area-wide planning agencies and providers of health services. However, these programs are primarily oriented to the concept of comprehensive health service rather than to a particular component such as dentistry. Although many of its extramural activities include major dental components and dental expertise is required for effective review and evaluation, Community Health Service has only two dentists on its own staff, both at headquarters. One works primarily in the general health area rather than in dentistry per se; the other is a consultant.

The Maternal and Child Health Service has dental program directors in four Regional Offices and a dentist at headquarters. The Division of Dental Health, in addition to a backup staff at headquarters, maintains a Regional Dental Program Director and a supporting staff in each of the ten HEW regions. The Division's regional staff, in addition to representing its own programs and those of the Bureau of Health Manpower Education, provides expert consultation and technical assistance for the other HEW agencies in Regional Offices as well as for other governmental agencies such as HUD, OEO, and Department of Labor.

PROGRAMS IN NON-HEALTH AGENCIES

Programs administered by the Social and Rehabilitation Service, the Office of Education and the Office of Child Development are of major significance in the Department's total dental service effort, though they are not primarily health-oriented programs.

Head Start and its offshoots, Health Start and the Parent and Child Care Center program, are administered by the Office of Child Development under a delegation of authority from the Office of Economic Opportunity. These programs have found dental decay to be the most frequent health defect among the young children they serve. Roughly $2.5 million was expected to be used in support of dental services in FY 1972. The Division of Dental Health,

under a reimbursement agreement with the Office of Child Development, provides professional assistance to and coordinates the Head Start dental program.

The Office of Education administers three programs which finance dental care for other than Head Start children It has a fourth program that provides a limited amount of support for dental health education activities The largest program, authorized under Title I of the Elementary and Secondary Education Act, provides grant support to states for special programs to meet the needs of educationally deprived children. An estimated $8 million of these grant funds are used by local school authorities to give the children the dental care services they need.

The Follow Through Program is designed to reinforce gains made by Head Start children. It provides comprehensive care to children enrolled in kindergarten through the 3rd grade. The most recent estimate available indicates that some $2.5 million would be spent for dental services in FY 1972. Essential dental care is also provided children enrolled in the Office of Education's Upward Bound Program, which is designed to assist under-achieving youngsters prepare for post-high school employment. About $700,000 were used to purchase dental services in FY 1970, the last year of available data.

Medicaid, administered by the Social and Rehabilitation Service, is the Department's major source of support for dental services. In FY 1970, the most recent year for which figures are available, federal share of the vendor payments for dental care totaled more than $83 million, accounting for 7 of every 10 dental care dollars that the Department spent extramurally that year. In FY 1969, before Congress lowered the income ceiling for the medically needy, such vendor payments for dental care amounted to $104 million. Dental payments were the only major category of payments to decline between FY 1969 and 1970. As a result, payments to dentists represented only 22 percent of all payments to licensed practitioners in FY 1970, compared with 28 percent in FY 1969 and 32 percent in FY 1968.

All but 12 of the 51 jurisdictions (states, territories and D.C.) participating in Medicaid provide at least some dental services. (Only Arizona and Alaska do not participate at all in Medicaid.) However, only very limited benefits are available in the vast majority of these 39 jurisdictions. Although dependent children under 20 years of age constituted about 60 percent of all beneficiaries receiving dental care, only 20 percent of the beneficiaries in this age range received any care in FY 1970

MANPOWER AND EDUCATION

Though dental manpower and education programs--like service programs--can be found throughout the Department, they tend to be concentrated in two agencies: the National Institutes of Health (NIH), primarily in the Bureau of Health Manpower Education (BHME), and in the Health Services and Mental Health Administration (HSMHA).

In FY 1971, more than $68 million was identified as expended in the Department in support of dental manpower development within NIH. The funds expended through HSMHA programs or programs of other Departmental agencies were not identified.

To improve physical facilities--beginning in FY 1965 and up to December 31, 1971--matching grants in the amount of $175 million were made to 38 dental schools by BHME. Through this activity, 1,195 new first-year places have been provided for freshmen dental students, and 2,331 first-year places have been retained by replacement and renovation of obsolete facilities. More recent commitments to 6 schools for $22 million in construction funds will add another 184 first-year dental student spaces.

Fifty-four awards made between 1966-1971 provided nearly $48 million for basic improvement grants and, between 1968-1971, awards in the amount of $40 million were made to 38 dental schools for special projects. In FY 1971 alone, $15 million was awarded to 36 dental schools for special projects.

As dental auxiliaries become an increasingly important part of the dental service delivery team, programs to support the development of new types of auxiliaries and to increase the Nation's auxiliary training capacity also are underway. Within the Bureau of Health Manpower Education, the Division of Allied Health, the Division of Dental Health and the Office of Special Programs carry out cooperative and complimentary programs related to the utilization and training of dental auxiliaries.

In FY 1972, the Division of Dental Health expended approximately $9 million for its various manpower activities. (This sum does not include funds programmed by DDH for other BHME organizations, e.g. $1.7 million for dental therapist* training.)

Among its activities, the Division develops and evaluates methods of recruitment, selection, and development of dental students and dental teachers; conducts research directed towards improvement in the quality of educational programs for dentists, dental faculty, students and auxiliaries; and experiments with instructional media, methodology, facilities and equipment used in dental education.

A 5-1/2 year study at the Division's Dental Manpower Development Center demonstrated that dentists can achieve greater productivity by delegating many of the functions they now perform to specially trained expanded function auxiliary personnel. Now, in support of the $4.2 million Training in Expanded Auxiliary Management (TEAM) grant program, which presently covers 20 dental schools, the Center trains dental and auxiliary school faculty members who will be teaching techniques of team dentistry and orients members of state examining boards and others to the use of expanded function auxiliaries in dental practice.

Auxiliaries themselves must also be developed to meet expected future demands. Making full use of opportunities provided by BHME programs which can support the training of such auxiliaries, the Division has programmed three regional centers which will design and develop teaching materials needed for training dental auxiliary students in selected duties.

Projects which will develop and evaluate dental therapist training programs also are being initiated using the aforementioned funds appropriated to other units of BHME. Two such

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*The term used in the Comprehensive Health Manpower Training Act of 1971 (P.L. 92-157) when referring to expanded function dental auxiliaries.

projects will develop coordinated statewide programs in community colleges for advancing the training of currently practicing auxiliaries so they can carry out expanded functions.

A small continuing education grant program administered by the Division and supplemented with contract funds has contributed to the establishment of a five-state continuing education television network encompassing Minnesota, Iowa, Nebraska, North and South Dakota. The project is attempting to provide a comprehensive high quality continuing education program for all dentists and auxiliaries in the region. To date, 13 hours have been simultaneously broadcast in the five states. Other continuing education activities, supported either all or in part by the Division, include the establishment of outreach programs for dentists to be conducted in community colleges, creation of courses to be presented on automated teaching machines, and a statewide multi-approach system of continuing dental education coupled with evaluation.

Consistent with provisions of the Health Manpower Training Act of 1971, dental school curriculum changes which will accommodate flexible, individualized instruction are being fostered by the Division through consultation and by support of conferences. Other DDH education activities include investigations of the optimal approaches to the design of dental equipment and facilities; development of the most practical ways of retraining dental personnel for new roles in dentistry; support of regional student conferences; investigation of educational methodologies; examination of recruitment and admission procedures for minority students; and development of films as an aid to recruiting minorities and women into dental education.

National, regional and area assessments of dental manpower resources and requirements have been made by DDH since the mid-1950's. National registers of dentists and dental hygienists are nearing completion and will be updated annually through a joint venture with the American Association of Dental Examiners. This new system permits small area sampling of the dentist population for the purpose of identifying dental practice characteristics and critical shortage areas with greater refinement than has heretofore been possible.

Lack of consensus about what constitutes shortage areas has led the Division to ask three state dental societies to propose criteria for identifying such areas–criteria which will reflect the views of the dental profession and which will identify unique local factors which apparently contribute to the shortage–and to make recommendations about ways to eliminate the shortages.

Resources of DDH focus heavily on the utilization of dental manpower. The Division has, for many years, attempted to exercise leadership with respect to increasing the skills of auxiliary personnel–both traditional and new types–and the interest and ability of professionals to employ them effectively in their practices. The four-handed dentistry concept–now a part of every dental school curriculum–was developed and supported by the Division.

Beyond this, projects are being supported to simulate various dental team configurations and the productivity changes that would result from changes in office organization and staffing as well as from changes in demands from the population for dental services. Other projects are measuring the actual impact of auxiliary utilization in private dental practices.

Related to the fuller use of auxiliaries in dental practice, the continuing analysis of the Nation's dental practice acts and the modifications they are undergoing has provided the basis for the development of a model dental practice act which will be proposed for adoption next year by the Council of State Governments. In the interim, the information available provides an effective tool for providing consultation to states considering changes in their practice acts.

Finally, a major six-nation study, conducted cooperatively by DDH and the World Health Organization, is underway in an effort to learn from other nations which have had long experience in providing dental services for their citizens. The study will analyze the characteristics of the methods employed for dental care delivery, stressing the manpower components of the systems and the effectiveness and efficiency of the systems when viewed from the perspective of the consumers and providers.

In HSMHA, among the numerous programs making contributions to the Department's total manpower effort, Regional Medical Programs Service supports continuing education programs. In early 1971, for example, eleven projects costing $1.3 million were being supported. It is estimated that in FY 1970, some 12,000 dentists received training through these projects.

Among other HSMHA manpower activities, the Federal Health Programs Service provides training through its facilities, which includes dental residencies and dental auxiliary development while the National Center for Health Services Research & Development supports projects that, for example, serve to evaluate dental auxiliary development and demonstration programs.

RESEARCH

Unlike the dental service and manpower functions of the Department which are fragmented, the disease-oriented dental research function falls almost exclusively within the province of the National Institute of Dental Research. FY 1971 expenditures were estimated at $35 million, some 3 percent of the $1.118 billion obligated for NIH's research activities. The FY 1972 budget was increased to $43 million.

The National Institute of Dental Research was established by the National Dental Research Act of 1948 and, under the authority of this Act, conducts and supports basic, clinical, and applied research and training in the causes, diagnosis, prevention and cure of oral diseases and disorders. Specifically, the Institute (1) conducts intramural laboratory, clinical and field research; (2) supports dental and medically related research and research training by assisting individuals, universities, and agencies through grants-in-aid for research projects, training, fellowships, and dental research institutes, and (3) conducts and supports collaborative and developmental research programs aimed at specific dental problems where major advance seems clearly possible.

The state of the art for dental caries, periodontal disease, and other major oral-facial problems and the potential for significantly advancing knowledge within a five-year period are described in a report prepared at the request of the appropriation committees of the U. S. House of Representatives and Senate.[2]

Dental caries: The National Caries Program–initiated with a $5 million add-on budget and now with a budget approximating $9 million–was implemented in order to find ways to reduce the incidence of caries and to extend the capability of dentists and other members of the dental team to prevent decay. Because of the complex nature of caries, it is unlikely that any one approach will completely solve problems of its prevention and control. Therefore, in the National Caries Program, efforts are directed to depressing the effects of all factors to a minimum through a combination of techniques. This concerted research effort offers prospects for making the universal problem of caries largely preventable before 1980. Progress is already being made in such areas as the development of an effective anti-caries sealant, new approaches to topical uses of fluorides, and the exploration of the caries-inhibiting effect of enzymes. The research is conducted through contracts with public and private research and development organizations and through epidemiological and field investigations conducted by the Institute's staff.

Periodontal disease: New initiatives to advance understanding of the causes and means of preventing periodontal disease also are underway. With current support approximating $5 million, a diversified program of research is conducted, including studies of the roles of enzymes in the destruction of periodontal tissues, observations on bone metabolism, and projects to explore important immunological aspects of periodontal disease. These activities are directed to a fuller understanding of the complicated biology and chemistry of the inflammatory process and ultimately the development of new preventive measures against at least some forms of the disease.

Other disease-oriented research: Other research supported or conducted intramurally by the Institute includes that related to the development of improved restorative materials; achieving greater understanding of the cause of dental and oral-facial anomalies and improved methods for their treatment; development of effective means for preventing herpetic lesions; and finding better ways to control pain and relieve anxiety connected with the provision of dental services.

The Institute also supports five dental research institutes and centers which, as opportunity presents, emphasize targeted approaches to the development and application of knowledge toward the prevention, cure, or control of dental and oral disease. Initiated five years ago, the program seeks to attract the knowledge and skills of scientists in disciplines not heretofore involved in dental research. They build on and extend existing institutional strengths, provide for participation of multiple disciplines, facilitate the cooperation of a broad range of biological, physical, and social sciences in the study of problems of common interest and interact with the education program of the parent university. This emerging network of dental research centers not only contributes new knowledge but also provides stimulating environments for training researchers and teachers. The program is already demonstrating its potential for helping to reduce the long existing lag between dental and other biomedical research.

Research training: The Institute serves as the principal source of support for the development of investigators in the dental sciences. The research training programs of NIDR also have contributed substantially to the development of trained faculty for dental schools. The proportion of full-time faculty in dental schools has grown from 25 percent to slightly more than 40 percent over the past eleven years. The number of full-time dental school faculty members engaged in research at least 10 percent of their time has grown nearly three-fold since 1958-59 from a low of 400 to over 1100 in the 1969-70 school year.

A notable impact has been in such important disciplines as materials science and corrective speech therapy, which had been woefully deficient in dental schools. Dentally-oriented training has also been provided in other major basic disciplines to provide the kind of broad research effort needed to generate productive answers to oral health problems. In recognition of the serious shortage of trained clinical investigators, a greater share of the training program is now being directed toward strengthening clinical research capabilities.

PROGRAM PROBLEMS, ISSUES AND RECOMMENDATIONS

The Advisory Committee, after reviewing the current dental programs of the Department against the backdrop of the major dental health problems of the Nation, felt it appropriate to make comments and recommendations for strengthening the overall program effort. Inasmuch as the Committee was unable to ascertain that the Department had any general philosophy or policies which guided the development of its dental health programs, the Committee, to guide its own deliberations, adopted the philosophy that dental services are an essential part of total health services and that every individual–whatever his situation–should have access to the services he requires. The Committee also is of the opinion that the Secretary of HEW is in a unique position to help make this right a reality, and moreover, that he has a responsibility to use all appropriate means to do so.

Therefore, to establish a sound base for all program development within HEW, the Committee recommends that:

I. The Department should squarely face the fact that the human suffering and disability resulting from oral and dental disease is of staggering proportions; it should acknowledge by adoption of appropriate policies that dental care is an essential part of total health care and that every person has a right of access to necessary dental services; and it should establish national dental health goals and formulate a plan and programs essential to their achievement.

Other comments and recommendations which follow relate to specific program elements: manpower, prevention, biomedical research, delivery of dental services, national health insurance, attention to children and concern for minorities and other groups having special needs.

MANPOWER

The prospect of providing sufficient dental care of high quality intensifies a most serious problem facing dentistry: the limited supply of dental manpower and its distribution. Already acute in some areas, the shortage of dentists and dental auxiliaries will inevitably become worse unless dental and allied schools continue at full capacity and solutions are found to the maldistribution of available resources.

Consequently, there is a paramount need to modernize, expand and develop the facilities where students are educated, improve the educational programs and increase the productivity of all members of the dental health team. Progress is being made by federally-supported programs in the use of self-teaching machines, closed circuit television and computer-assisted teaching programs for dental students, auxiliaries and for the continuing education of dental practitioners outside the university setting. Dental research institutes in university settings also give attention to research training in applied dental science, research fellowships for students in those centers, and accordingly, act as hubs for disseminating continuing education to private practitioners Programs related to the recruitment of well-qualified teachers and researchers are paying off. Efforts by private and public agencies to attract young people from minority groups to careers in dentistry show promising results and should be expanded.

The most efficient use of scarce dental skills can be secured through the extended use of dental auxiliaries. Dentists today are employing larger numbers of auxiliaries and, in so doing, are increasing the amount of services they can provide and the number of patients they schedule each year. Statistics from the American Dental Association show that dentists, through the greater use of auxiliaries, are scheduling many more patient visits per year than a decade ago. And the trend of employing multiple auxiliaries is continuing. In addition, the dental profession is using auxiliary personnel in more efficient ways than formerly as more dental graduates are better prepared and more practicing dentists learn the new methods of working with auxiliaries who possess advanced and additional skills. Even more recent than these developments, and of major significance, are the new Division of Dental Health-supported TEAM (Training In Expanded Auxiliary Management) programs in many dental schools. This further increases the productivity of newly-trained dentists by teaching them to make better use of auxiliaries with expanded clinical duties. As encouraging as these advances in the development of dental manpower and services have been over the past decade, the very difficult problem of balanced distribution of dental services remains largely unsolved. Financial incentives to encourage recent graduates to practice in underserved areas have not proved attractive enough. The National Health Service Corps Program is too new to evaluate. Certainly this major problem of distribution of manpower is one that requires intensive study, experimentation and development.

Regarding dental manpower, the Committee makes the following recommendation:

II. The dental manpower programs of the Department should be improved by increased efforts to graduate more dentists and auxiliaries; to overcome problems of maldistribution; to improve educational programs; to achieve greater efficiency in the delivery of dental services through the full use of dental auxiliaries; and to recruit more members of minority groups and more women into the dental work force.

As part of this recommendation:

a. Intensive research should be undertaken and supported by governmental funds to determine factors that influence the distribution of dental manpower, to design possible solutions to the maldistribution problem, and to experiment with methods that would alleviate and solve these critical problems.

b. Support should be continued and increased for the improvement of educational programs and the development of new teaching methods in schools for dental students and auxiliaries.

c. Efforts by private and public agencies to attract promising young people, especially from minority groups, to dental careers should be encouraged and strengthened. Efforts to bring more women into the profession of dentistry should also be intensified

d. Federal support should be continued and increased for the development and operation of more dental auxiliary training programs, especially expanded function auxiliaries, in community colleges and other post-high school programs, and commensurate attention should be given to the development of teachers for these programs.

e. Greater emphasis should be given to training expanded function auxiliary concepts for dental students as well as for dentists and auxiliaries already in the work force.

f. Greater efforts should be made to recruit military-trained dental auxiliaries upon the discharge from the military and to make full use of their skills.

PREVENTION

The best way to improve the Nation's dental health is to prevent dental disease, Dental caries can largely be prevented and to a lesser degree periodontal disease can be controlled. Their current prevalence simply indicates that we have failed to apply fully the scientific knowledge we have Fluoridation, for example, decreases the incidence of tooth decay by two-thirds; it is safe, economical, simple to implement and has been called an ideal public health measure. Yet after 50 years of research and more than 25 years of practical experience, 12,000 communities still have not started fluoridation programs. Fluoridation is a major health economy–it cuts the cost of treating tooth decay in half. That fact has been demonstrated already in several large cities and in cost studies of Head Start and Neighborhood Health Center programs.

Perhaps the most encouraging recent development in fluoridation is the enactment of state laws requiring the institution of fluoridation programs. Seven states–Connecticut, Minnesota, Illinois, Delaware, Michigan, South Dakota, and Ohio–now have such laws. Bills for mandatory fluoridation have been introduced in other state legislatures. All this is very much to the good, but it is just not good enough. The total increase in the number of fluoridation programs throughout the land continues to be deplorably slow. Only half the people in the United States receive the fluoridation benefits they should have.

Too frequently, surveillance of fluoridation programs has been lacking after fluoridation was installed and the switch turned on Recent statewide fluoridation evaluation surveys conducted by the Environmental Protection Agency have revealed that more than half the water samples collected from the distribution systems of selected fluoridated water supplies contained fluoride ion levels in deficient amounts Thus, there is a need for increased and continued attention to the maintenance of fluoridation levels in community water systems where fluoridation programs have been instituted.

There are some workable, though less effective, alternatives to community water fluoridation For those children who do not have access to a community water system, the fluoridation of school water supplies can be substituted. Or the use of self-administered topical fluorides, such as special fluoride pumice pastes, may prove beneficial. These newer methods of delivering fluoride benefits, while admittedly not as good as community fluoridation, may nevertheless be the most practical preventive approach for rural children.

There are 14,000 new victims of oral cancer each year and most of them can be treated successfully if their condition is detected early enough But improved methods of early detection by dentists and physicians are needed in addition to the currently available continuing education approach.

Schools, private practitioners and community information programs can all help develop the preventive approach to the control of dental diseases. The inclusion of preventive dentistry theories and applications in the dental school curriculum can help develop dentists who have the knowledge needed to teach preventive dental practices to patients. Continuing education courses for those graduated can help emphasize prevention for the practicing dentist. It is also important that methods for motivating patients to want to keep their mouths clean be developed and implemented

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It has been noted that a day-to-day personal oral hygiene program plus periodic visits to the dental office provides substantial protection against periodontal disease. An oral hygiene program includes basic plaque control–proper use of disclosing tablets, brushing and flossing methods Knowledge of these methods can be utilized by dentists to motivate patients to adopt an effective oral hygiene program that can be practiced routinely at home

Proper plaque control methods can also be taught through health education in the schools as well as through dentally sponsored community information programs Preventive dentistry programs in individual classrooms and mass media can be effective in getting knowledge applied for the prevention of dental disease

School programs, patient education in the dental office, and media programs should also include nutritional counseling on the basic dietary requirements helpful in disease prevention.

The Committee therefore makes the following recommendation in the area of preventing and controlling dental diseases:

III. A grant-in-aid program should be established to provide support for the purchase and installation of fluoridation equipment and for surveillance of fluoridation programs. An intensive nationwide health education program also should be initiated to make the public aware of what can be done to prevent and control dental diseases.

As part of the implementation of this recommendation, the Committee urges that:

a. A national fluoridation program be started that would provide grants for the purchase and installation of fluoridation equipment for community and rural school water supplies. Financial assistance by the Department to help meet the costs of installing and operating the programs for a specified time should be inaugurated.

b. Formal cooperative efforts should be established on fluoridation surveillance and training programs between the Office of Water Programs, Environment Protection Agency and the Department of Health, Education, and Welfare

c. Evaluation of the long-term results of plaque control programs be undertaken.

d. A dental health education program for parents, children, and personnel working with children should be instituted as an essential component of health programs of the Department.

BIOMEDICAL RESEARCH

Great advances have been made in the technology of dentistry and dental materials, but there is continuing need for research on the causes and prevention of caries, periodontal disease and dental anomalies The new emphasis by the profession on a preventive orientation rather than solely restorative requires a solid, scientific foundation on which to base the promotion of various preventive measures to the profession and the public Such research is being supported and conducted primarily by the National Institute of Dental Research. The Committee recommends:

IV. There should be continued emphasis on targeted biomedical research to expedite the development of new and more effective preventive measures. Accordingly, the five-year plan of the NIDR for the optimum development of the Nation's dental research effort should be given high priority by the Department in the allocation of financial resources.

DELIVERY OF DENTAL SERVICES

Traditionally, research in dentistry has concentrated on biological and technological problems rather than on the delivery, financing and organization of dental services. Too little attention has been paid to such major issues as the motivation of patients to maintain their dental health, the reasons for utilization of care by the public, and the various means to increase the productivity of dentists and the efficiency of their practices. In the last decade, however, it has become evident that increasing the productivity of dental manpower and the provision of more care to more people depends in part upon expanding research in the dental care delivery system. There is now considerable emphasis on developing and defining the expanded use of dental auxiliaries and on training dentists and auxiliaries in new roles. But this is not enough. The Committee recommends:

V. A major effort should be launched immediately to conduct a coordinated program of research and development related to the organization, financing, delivery and utilization of dental services, and adequate funds for this purpose should be made available to the Division of Dental Health.

Among the areas requiring special attention are:

a. Research on the comparative advantages to patients and dentists of various modes of practice and practice management systems. Special emphasis should be given to group practice where dentists and other health personnel work as a cooperative team, sharing facilities, patients, income and responsibilities.

b. Establishment of criteria to measure the quality of dental care on an individual basis together with development of effective professional peer review systems.

c. Development of ways to motivate patients to assume necessary personal responsibility for maintaining their dental health and also for seeking dental care.

d. Documentation of utilization patterns in care programs and identification of reasons why individuals do or do not seek necessary dental care.

e. Development of systems for providing dental care in areas without resident dentists.

f. Comparison of different systems of dental prepayment, on such issues as cost-benefit, use of copayment and deductibles, different benefit patterns, and different modes of payments to providers

Within the general context of program deficiences related to dental care, the Committee feels that particular comment needs to be made about the lack of dental programming within the Health Services and Mental Health Administration. HSMHA has a budget of some $2 billion a year and more than 25,000 employees. Yet, the Committee had not been able to discover that any hard thought has been given to dental affairs within HSMHA's purview, except for generalized comment about the importance of dental health and a token appointment of a "HSMHA dental coordinator," without staff, who has retained all of his former responsibilities and remains submerged organizationally. In its organizational recommendations, the Committee includes a suggestion that would, it believes, begin to reverse this present, unacceptable void in dental programming within HSMHA.

NATIONAL HEALTH INSURANCE

Dissatisfaction with the Nation's health care system is being discussed with great fervor at all levels of our society. The dissatisfaction stems from people recognizing that preventive health measures and treatment of illness are not equally accessible to all. Government alone cannot solve the complex problems of health care. For effective planning and implementation of a dental component in national health insurance, it will be necessary for the government to work closely with the dental profession, third party agencies and the public to ensure that the dental health program will be to the benefit of all people.

The Committee believes that improvements in the Nation's health care delivery system are indicated and that such changes inevitably will involve the delivery of dental care. Because dental health is an essential component of total health and an essential part of everyone's well-being and appearance, the Committee is emphatic in recommending that dental services be an integral part of every comprehensive health care program. Numerous bills have been introduced in the Congress to establish some form of national health insurance. We believe that whatever national health program is adopted should contain a realistic dental component that is within the capability of an expanded and more productive dental work force to deliver, that is professionally sound, and that will be accepted and valued by the public. The Committee also recognizes that there can be no real solution to the Nation's dental health problems unless the public is educated to the value of oral health.

The Committee has noted the dental profession's long-standing policies to endeavor to make comprehensive, quality care available to everyone in a manner that respects the dignity of the individual regardless of economic status, geographic residence, national origin, race, creed or color.

The Committee is convinced from reports and available data that a comprehensive dental health program for all people of the United States is achievable if careful planning and efficient programs are created and maintained.

Formation of the program will require new legislation, additional dental manpower, the application of new financial methods of payment, the setting of priorities and the use of surveillance and evaluation procedures.

Too frequently dental services have been considered an add-on benefit rather than an integral part of health care. Most, but not all, of the legislative proposals on national health

insurance include some level of dental care. The proposal supported by the Department during the 92nd Congress conspicuously lacked dental provisions. It may be necessary for the dental component to provide different coverages and different priorities for different population groups than the medical components of the program Such differences, when necessary, should be based on fundamental differences between dental problems and medical problems. Most dental problems require different treatment methods, appointment schedules, priorities, clinical skills and payment methods than medical problems. These differences must be taken into account within the framework of the total health program.

The Committee had for its consideration the latest information and data on dental programs in this country and it also considered dental programs operating in other parts of the world. All recent studies of dental health problems in this country and others lead to the conclusion that the prevention of dental disease through public health measures such as fluoridation, effective preventive dentistry practices in dentists' offices, intensive personal dental hygiene regimens, and a concerted, organized treatment program for school-aged children result in maximum dental benefits If a program of prevention and treatment for all school children were instituted in the United States, the Committee believes the dental health status of the country would be significantly improved in a generation.

With respect to national health programs, the Committee makes the following recommendation:

VI. The Department should propose and support a national health insurance proposal that includes at the outset a dental component that gives priority to preventive and therapeutic services for children and emergency dental care for all.

In this regard, the Committee calls attention to its interim recommendations which appear in Appendix II of this report

ATTENTION TO CHILDREN

The massive prevalence of dental disease among all elements of the population makes it improbable that the Nation is going to allocate sufficient resources at one time to permit everyone to have comprehensive treatment. Given that assumption, choices must be made and priorities set.

This Committee endorses unequivocally the long-standing position taken by the dental profession and others involved in dental health questions that the first priority belongs to children. It believes that preventive services for children should be the central concern of all Departmental programs that deal with the delivery of dental care services.

Special attention to children is justified on any number of grounds. From the point of view of economics, preventive services for children are susceptible to realistic controls both by way of the numbers involved and the kinds of services that constitute comprehensive care for them. Extensive prosthetic services, for example, are required to a far lesser degree when treating children than in treating other age groups

From the professional point of view, investment in children's dental health concentrates funds on the precise groups where care will yield the richest and most enduring dividends.

And finally, from the point of view of the over-all dental disease problem, the Committee agrees that if we can bring a generation of children to maturity while they are in possession of sound oral health, it is the single most significant action the Nation can take in reducing the existing backlog of disease while preventing its further growth.

Much more can be done than is accomplished at present in terms of organized methods for doing something about the root causes of the present backlog of existing disease among children The Department, for example, has shown almost no awareness, in terms of money allocation, of the potential that might be realized in working with children with respect to their dental needs within the school system For some years now, dental experts have been focusing increasing attention on how children can be reached through the school system in a way that is well-organized, effective and acceptable to the children and their parents, and various proposals have been brought forward in recent years by individuals and organizations.

The Committee recognizes that there are divergent views as to the extent to which dental care should be provided by auxiliaries not under the direct control of a dentist physically present, and that no consensus exists as to any one program which will be most appropriate and effective in all instances The concept of reaching children for essential, basic dental care through a school-based program holds considerable promise, however, and it should be possible to resolve differences by further study or by establishing pilot programs using alternative plans. The difficulty of reaching agreement as to the best way to proceed must not continue to block progress when there is general agreement that a high priority need exists in this area. Immediate attention should be given to an assessment of these various proposals with the objective of determining how best to solve the problem of improving the dental health care of the Nation through an attack on the dental health problems of its school-aged citizens.

The Committee suggests that the most effective approach to this assessment is through the appointment of a joint governmental and non-governmental task force, thus making maximum use of the available talent both within and outside the ranks of government. The task force should not only evaluate all the various proposals that have been made for the establishment of school-based dental programs but conduct whatever additional studies it may find necessary in order to produce a definitive assessment and recommendation. Without restricting the generality of the assignment, the Committee suggests that the evaluation include an assessment of the appropriate combination of professional and paraprofessional personnel to be utilized, the most effective administrative mechanisms, the necessary support services (such as facilities, transportation, etc), and sources of funds to support such a program adequately

Obviously, we can't ignore everyone else in society while directing our attention solely to children. The aged are entitled to attention; so too are those who are family breadwinners. But in terms of priority, preventive services for children has a rightful claim as being the most important step for the country to take.

The Committee makes the following recommendation:

VII. Departmental dental efforts should give priority attention to the prevention and control of dental diseases of children at least up through secondary school age.

Emphasis should be placed on exploring the achievement of these goals within the framework of school-based programs. Accordingly, the Secretary should appoint a combined governmental and non-governmental task force whose charge would include, but not be limited to, the study and evaluation of all aspects of a school-based children's dental care program and the making of appropriate recommendations thereupon.

MINORITIES AND SPECIAL GROUPS

The United States is today the most affluent, most powerful Nation known to history. Yet, it has its forgotten millions people who live daily with deprivation and despair. Among the essential elements of a civilized society that are withheld from these millions, health services constitute one of the most hurtful deprivations.

For many, such deprivation is essentially a matter of economic status. For others–including many blacks, Mexican-Americans and additional minority groups–discrimination on not only the economic level, but also the social and personal has taken an especially cruel toll.

The consequences of this discrimination is readily and shamefully evident with respect to oral health. The American Dental Association's *Survey of Needs for Dental Care, 1965*[3] meticulously documents the differences in dental treatment received by persons of disparate incomes as well as the lesser amount of attention received by minority groups.

Additional studies in recent years have yielded results such as these:

(1) A 1960 survey of 2,564 indigent children ages 6 to 15 living in Chicago showed that while 97 percent of them had decayed teeth, only 8 percent showed evidence of having received prior restorative treatment Twenty-two percent had missing permanent teeth and 25 percent had permanent teeth requiring extraction because of decay. Among children aged 11 to 15 in this group, 12 percent had ten or more decayed permanent teeth and no restorations.

(2) A 1967 survey of 3,911 five-year-old children of all economic levels in Contra Costa, California showed that while 24 percent of the children from the median-income level had been to a dentist in the previous twelve months, only 6 percent of children in the lowest-income level had done so While only 14 percent of the children in the median-income level had never been to a dentist, 52 percent of the poorest children had never been.

(3) The National Health Survey, 1963-64, indicated that among children aged 5 to 14 from families with incomes of $2,000 or less, 68.7 percent of the children had not been to a dentist in the previous two to four years and 58.3 percent of them had never been to a dentist. For children of the same age but living in families with incomes of $10,000 or more, only 9.3 percent had never been to a dentist

(4) Data from various National Health Surveys show that of the total number of dental visits for children in the income groups under $2,000, 31.8 percent were for extractions; the comparable figure for children in the income group of $7,000 or higher is 4.8 percent.

5) The 1967 Survey of Needs for Dental Care shows that low income dental patients in general need 14 times as many extractions due to decay and need dentures 20 times as frequently as those with incomes of $6,000 or higher.

There can be no excuse for these prevailing conditions. The entire Nation is under serious obligation to take whatever exceptional steps are necessary to change the picture. The dental profession and the Department have a special obligation with respect to oral health needs of the deprived

Accordingly, the Committee recommends that:

VIII. High priority attention should be given to developing mechanisms assuring the availability of high quality dental services to minorities, low-income persons and other population groups having special needs.

ORGANIZATIONAL IMPEDIMENTS AND RECOMMENDATIONS

Two events that took place in the mid-Sixties profoundly changed the character of health programming in the Department They were, first of all, the adoption of the principle of comprehensive health programming--a departure from the previous categorical or disease-oriented approach--and secondly, an acknowledgement that the Department had a greater, more active role to play in helping to deal with the Nation's growing health delivery and health manpower problems.

Even prior to this time, dental programs in the Department had a sufficiently difficult time in attracting the sympathetic attention of Departmental policy-makers. One of the more ironic examples of that is the fact that efforts were made for years to achieve a categorical grant for dental disease despite the indifference of the Department. It was finally achieved a bare three years before categorical grants were all but abolished.

Since the mid-Sixties, the problems of dental programs have become increasingly critical The fact that dental programs account for less than 2 percent of the Department's health budget--as opposed to some 9 percent of the private health dollar--is significant not only in itself but as a symbol of the inattention given dental health by the Department.

With the move toward comprehensive health programming, the responsibility, legal authority and funds for dental activities have become diffused in what are now several nearly independent agencies of the Department; such as HSMHA, NIH, SRS, OE and OCD. There has been an apparent lack of interest on the part of those having responsibility to accept it on behalf of dental programming. Frequently, those non-categorical programs with clear legal authority for certain dental activities choose to fund an occasional project as acknowledgement of responsibility, and a protection of their administrative prerogative, while at the same time pleading they do no more because dental activities really are the responsibility of categorical dental agencies, especially the Division of Dental Health. No one has explained how the Division should be expected to carry such weight with an operating budget that has never exceeded $12 million a year

Compounding this problem has been the sequence of changes made at various times in recent years in the administrative and organizational structure of the Department.

Over the years, there has been considerable variation in the way in which the Department has addressed itself to the serious problem of coordination that invariably exists in an agency of such massive size and broad scope No one, so far as the Committee is aware, would yet claim that these problems have been totally resolved And the fluctuation of approach has itself given rise to some administrative anomalies whose existence hinder optimum operating efficiency

One such anomaly concerns the Office of the Assistant Secretary for Health. The occupant of that post is, by title and intent, the chief health officer of the Department. Yet, massive health programs are in fact outside his jurisdiction and largely unsusceptible to the coordinating efforts of his Office

While questions relating to the Office of the Assistant Secretary for Health are not wholly within the purview of this Committee, the consequences of the narrow limits of that Office substantially affect matters that do make up the Committee's task. Steps need to be taken to give to the Office of the Assistant Secretary for Health the actual authority to match its theoretical responsibility. Certainly, it is puzzling to outsiders that the Department would go to the lengths it does, quite properly, to recruit nationally recognized and extraordinarily well-qualified health leaders to fill the Assistant Secretary post and then deny him administrative authority over such programs as Medicaid, Head Start and a host of others that possess implications for health.

This anomaly has had chilling consequences down the line. With respect to dentistry, it has meant that there is literally no one in a position to have a Departmental overview of all dental programs, much less the authority to work for better coordination of them. No one below the Office of the Secretary is in an administrative position to carry out this fundamental task.

Of equal seriousness, too little has been done of an interim nature to try and ameliorate the difficulties until such time as the Assistant Secretary has appropriate authority given him. In December, 1969, a special assistant for dental affairs to the Assistant Secretary was established. However, the post was filled for only a short time and has now been abolished.

The history of the position of Chief Dental Officer of the Public Health Service is also deserving of note. Departmental attitude toward the post is most difficult to understand. The post is a statutory one, decreed by Congress.* The last occupant of the post retired in 1967. No successor has yet been appointed despite repeated requests from dental groups outside government and inquiries from Congressional sources. At the same time, equivalent posts for other elements of the PHS have become vacant and been promptly filled. The Department's stubborn refusal to fill the dental post is not only inconsistent with its other actions, it is so inexplicable as to raise serious questions about HEW's commitment to dental health.

Accompanying the diffusion of authority and funds for dental health programming is a hierarchical downgrading of dental organizations throughout the Department with the exception of NIDR. Lack of organizational status in and of itself is not necessarily bad, but the indirect effects can be and have been detrimental. As an important example, the lack of opportunity for dental program directors to discuss dental problems and dental program needs before committees of the Congress during the appropriation cycle or with high level agency or Department officials on questions of policies and priorities--a result of their unfavorable organizational status--is in the long run a serious obstacle to the development of essential dental programs.

The Committee is convinced that modifying the organizational structure within which HEW dental activities are carried out and changing the administrative mechanisms which govern them are a necessary first step in the attempt to achieve more rational and more equitable treatment for its dental health activities. Changes are needed to provide for improved planning

*Subsection 205(b) of the Public Health Service Act

and coordination and, particularly, for dental input sufficient in quantity, quality, and timeliness to help shape better informed, more realistic policies and practices regarding dental health for the many so-called comprehensive health activities within HEW. Far too frequently, these programs have developed with little or no concern for the dental health of the people the programs are designed to serve

Two options at the extremes of the continuum of organizational possibilities were considered by the Committee and rejected These were: (1) consolidating to the maximum extent possible all HEW dental activities, along with appropriate staffs and financial support; and (2) dispersal and complete integration of dental activities throughout the various major programs and agencies of HEW

The former was rejected because it is inconsistent with the philosophy of organization which prevails within the Department, and it would tend to isolate dental activities. The latter was rejected as a sure means of exacerbating extant problems of planning and coordination, and would only make it easier for the Department to avoid confronting the very real issues which must be faced with respect to the Nation's formidable and growing dental health problem

Even organizational changes that are intermediate to the two extremes were not seen by the Committee as being so certain of success that the benefits to be achieved appeared worth the risks involved in further organizational disruption of the kind which has continually plagued the dental activities over the past decade and, particularly, in the past few years Among such intermediate organizational changes considered, but eventually rejected, were: (1) consolidation of all NIH dental activities into a single entity within NIH and all dental activities within HSMHA into a single entity within HSMHA; (2) consolidation and transfer of DDH, NIDR, and the dental branch of DPHPE to HSMHA, and assignment of dental planning and coordination functions for the Department to that organization; and (3) transfer of DDH service programs to HSMHA, while retaining its manpower programs in BHME.

To the Committee, the organizational placement of DDH was a matter of particular concern–a concern which stems from the fact that DDH has responsibilities which cut across agency lines The Committee is aware of the fact that the subject of DDH's organizational placement had been examined on previous occasions by other groups The last of these was a 1970 study conducted under the direction of Dr Leonard Fenninger.[4] It focused specifically on the feasibility of transferring the service components of DDH to HSMHA. The study group, drawn from HSMHA and NIH, concluded that "the gains from transferring the designated service functions of DDH to HSMHA at this time would be far outweighed by the losses that would be sustained by the separation of the now closely-related DDH research, education and service functions, and by the likely dispersal of the DDH service functions throughout the various HSMHA programs "

This Committee concurs with these earlier findings But it is not prepared to conclude only that the transfer of DDH service functions to HSMHA is not feasible and leave unresolved the question of how to improve planning and coordination of dental activities within HEW Therefore, the Committee finally concluded that the most prudent approach would be to add elements to the structure which would enhance the ability of existing organizational units to function effectively and increase their opportunities for having purposeful, timely input, as appropriate, in the planning and development of HEW health programs.

The recommendations that follow, taken altogether, would provide an opportunity for overcoming many of the present deficiencies which retard dental program development in HEW.

The recommendations are:

IX. Establish a Deputy Assistant Secretary for Dental Affairs in the Office of the Assistant Secretary for Health.

The incumbent of this staff position would serve as principal advisor to the Assistant Secretary with respect to the planning and coordination of dental activities within the agencies responsible to him and, through appropriate assignment of responsibility by the Secretary, would serve as principal dental advisor to agency heads of SSA, SRS, and OE.

This position should be staff rather than line but must be given sufficient visibility and support to enable the incumbent to function actively. The incumbent would be expected to keep well-informed about health matters within HEW generally; to recognize and bring to the attention of those responsible for action in any program area, opportunities which may present themselves for improving the Department's dental health programs and for augmenting health programs now lacking dental components; and to serve as an advocate within the Office of the ASH for legislation, regulations, and policies which would further the capacity of the Nation to deal effectively with the dental health problem.

In addition to an appropriate staff, which should include the Chief Dental Officer, the Deputy Assistant Secretary should be authorized to call on appropriate operating programs of HSMHA and NIH for staff support in carrying out his functions.

X. Establish a Deputy Administrator for Dental Affairs in the Office of the HSMHA Administrator.

The incumbent of this staff position would serve as principal advisor to the HSMHA Administrator with respect to the planning and coordination of dental activities within HSMHA and would serve as principal HSMHA contact with the NIH dental program directors (NIDR and DDH).

The incumbent would carry out functions for HSMHA similar to those carried out for the Department by the Deputy Assistant Secretary for Dental Affairs.

In addition to advising the Administrator on dental aspects of program planning, legislation, regulations, personnel utilization and appropriateness of dental functions carried out in the various programs of the Agency, he would establish a system to monitor the nature and extent of all intramural and extramural activity supported by HSMHA, to evaluate the impact of HSMHA dental activities and to identify opportunities for increasing and improving HSMHA dental programming within policies and guidelines established by the Administrator.

Appropriate staff support would be required

XI. Establish a Committee on Dental Health as a permanent advisory body to the Secretary.

A permanent advisory body to the Secretary, composed of a small (9-12) number of members drawn from dental and other professional groups, consumers and representatives of the health industry, would serve as an organized instrument through which the Secretary could obtain outside opinion concerning the development and operation of dental health programs within HEW. It could serve as a sounding board with respect to proposals for establishing new programs or modifying existing ones, for establishing program and budget priorities and for reviewing proposals for new legislation, regulations, or program guidelines.

The Committee should address itself mainly to questions or issues periodically agreed upon jointly by the Committee and the Secretary and should systematically report to the Secretary on its deliberations and findings or recommendations.

It is recommended that the Committee serve as advisory to the Secretary inasmuch as it is only at the Secretary's level that all programs within HEW having dental components are encompassed If at some future time the responsibilities of the Assistant Secretary for Health are broadened to include all health activities of HEW, then the Committee could properly be made advisory to him rather than to the Secretary.

Staff services in support of Committee activities would be required.

XII. Retain the organizational placement of the National Institute of Dental Research.

Though the National Institute of Dental Research has not yet achieved parity with the other Institutes with respect to budget and staff, it is making steady progress and has plans for development of a program of biomedical research which is imaginative and worthwhile and appears to be supported by the Director, NIH. As head of the primary dental research arm of HEW, the Director of NIDR should continue to serve as principal advisor to the Director, NIH, with respect to biomedical research of dental significance.

XIII. Retain the organizational location of the Division of Dental Health with all its existing program components in the Bureau of Health Manpower Education.

The Division of Dental Health is unique inasmuch as it engages in all types of dental functions except biomedical research. Much of its strength comes from the close coordination and the interrelationships that exist between the various program elements making up the Division The Division has never received the fiscal and staff support that its scope and depth of activity warrant In the view of the Committee, it is important that the Division retain budget visibility, that the budget be increased substantially, and that special efforts be made to develop a long-range plan for the full development of the Division's programs.

To this end, it is urged that the Secretary require the Division to prepare a 5-year plan by July 1, 1973, both in terms of program substance as well as budget and staff requirements, for the development of a program which will take full advantage of opportunities which exist for successfully confronting the Nation's dental health problem.

The Committee believes that there is nothing to be gained at this time from the transfer of any functions (particularly service functions) out of the Division. It would oppose such transfers. In making this latter statement, the Committee is not adhering to a status quo position with respect to eventual transfer of DDH service functions to HSMHA. Rather, it concurs in the Fenninger report recommendation that, in part, stated: "The establishment of an Office of Dental Affairs (in HSMHA) can be viewed as the first step in establishing a firm foundation for improving the effectiveness of the dental activities in HSMHA. After such a foundation is well-established, the orderly transfer of DDH service functions to HSMHA might then be very appropriate and could serve to strengthen both the DDH activities and those of HSMHA."

With the establishment of the two recommended positions and the Advisory Committee, the opportunity for much better planning and coordination of dental activities within the Department would be afforded.

The action also would do much to eliminate the concerns felt so keenly by those both within and outside the government that there is no strong voice for dentistry within the Department, that the Department does not consider dental health important, and that the Department is wary of confronting dental health issues because of the admitted high cost of solving the total dental health problem.

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1. Dental Health Related Programs in Federal Agencies: Division of Dental Health, NIH; November, 1969.

2. Oral Disease: Target for the 70's: National Institute of Dental Research, NIH; December, 1970.

3. Survey of Needs for Dental Care, 1965: American Dental Association; November, 1966-June, 1967.

4. DDH and HSMHA Dental Service Activities Report: Office of the Associate Director for Health Manpower, NIH; April, 1970.

*Additional materials not specifically referred to in the body of this report are listed in Appendix IV.

APPENDIX I

DIMENSIONS OF DENTAL HEALTH PROBLEM

—Dental disease is all but universal;

—Fewer than half the people in this country have dental exams or treatment in a given year; far fewer than that receive dental care on a regular basis;

—By age two, approximately 50 percent of America's children have experienced tooth decay. On entering school, the average child has three decayed teeth and by age 15, the average child has 11 decayed, missing or filled;

—Approximately 50 percent of the children in America have gingivitis, which can lead to progressive periodontal disease, a major cause of tooth loss in adults;

—Nearly 50 percent of all children under age 15 have never been to a dentist. This percentage is substantially higher for children in rural areas;

—Almost 70 percent of the children in poor families have never been to a dentist;

—Over 50 percent of all Americans over age 65 have lost all of their natural teeth;

—Of the total adult population of approximately 110 million, more than 20 million have lost all their natural teeth; of the 90 million with teeth, 25 percent have destructive periodontal disease and over 50 percent have some stage of gingivitis;

—Cleft palate, with or without cleft lip, occurs about once in every 700 births or about 6,500 such births annually;

—Oral cancer is discovered in 14,000 new patients each year and accounts for over 7,000 deaths yearly Of those who have had treatment, approximately 22 percent are in need of maxillofacial prosthesis;

—For every 100 Selective Service recruits, the Armed Forces needs to perform or supply 500 fillings, 80 extractions, 25 bridges and 20 dentures

STATEMENT OF JEANNIE I. ROSOFF

Mrs. ROSOFF. Mr. Chairman, I am the director of the Washington Office of Planned Parenthood Federation of America, the national voluntary organization in the field of family planning for the past 50 years. Our 192 affiliates currently provide clinic services to over 750,000 low-income patients a year. Although the number of patients enrolled in our clinics has almost doubled during the past 5 years, the most spectacular growth in patient enrollment during the same period has occurred in the public sector through hospitals, health departments, community action agencies, and a variety of other institutions.

This growth has largely occurred since the passage of the Family Planning Services and Population Research Act of 1970—title X of the Public Health Act—which this subcommittee recently succeeded in extending for another year.

We estimate, according to reliable surveys, that 1.9 million low-income women were enrolled in organized programs at the end of fiscal year 1972, and that this number is probably close to 2.5 million at the present time. This means around 5 million patient visits a year. Almost all of the financial support for the public sector programs comes from the Federal Government in the form of project grants for a total of $122 million in fiscal year 1973. These funds are, or were, administered by the National Center for Family Planning Services within HSMHA.

My purpose here today is to discuss the organizational arrangements in effect in DHEW during this period of intense growth, review DHEW and OEO administrative arrangements prior to the establishment of the National Center and attempt to forecast what impact the current reorganization may have on this particular program and, by inference, on other health programs. Prior to the consideration of the title X legislation, the DHEW family planning programs were administered by the Children's Bureau, then located in the Social and Rehabilitation Service. Although its family planning expenditures under title V of the Social Security Act were in the order of $25–$27 million a year, it had no specialized staff accountable for the program, either at the national or regional levels.

On some occasions, it actually found itself unable to expend the funds appropriated for the program by Congress. Mounting criticisms of the Children's Bureau's management—or nonmanagement—led to a number of Congressional proposals for the statutory creation of a specialized family planning agency. In a special message to the Congress, the President acknowledged that "programs should be better coordinated and more effectively administered."

In October of that year, the National Center for Family Planning Services was created. The OEO, which had awarded family planning project grants funds since its inception, did not have any specialized staff until 1967 when, as a result of Congressional prodding, it expanded its program and established an Office of Family Planning in the Division of Health Affairs. At its heyday, the Office of Family Planning never exceeded 5 professional staff members at headquarters to oversee the spending of $15 to $20 million. At the regional level, there were no OEO program specialists assigned full time to family planning.

I can attest from my experience that in spite of the energy and resourcefulness of all concerned, the OEO Office of Family Planning was often unable to keep track of such elementary information as the exact number, location, and level of funding of OEO supported programs. Our office, for several years, had to compile an independent listing of OEO grants and share it with the agency which did not have the capacity to collect, verify, and analyze the information on its own. I also know that the staffs of the national center could now testify from their experience with transferred OEO programs as to the deleterious effects of inadequate staffing and nonspecialized management on medical standards and the quality of services generally.

The establishment of the National Center for Family Planning Services provided one visible, accountable agency to administer family planning grant funds support first by title V of the Social Security Act, then by title X of the Public Health Service Act, and to take over the administration of OEO projects, a process still partially in progress. We have had enough experience with the national center since its inception to be familiar with, and responsive to, the criticisms which have been made by DHEW officials of its functioning. We are perhaps less critical than they are, first, because we know that its existence represented a tremendous improvement over the former situation and second, because we are not sure where the responsibility for the malfunctioning lies.

NCFPS suffered most from its inability to make policy decisions and to communicate these decisively, and uniformly, to the field. However, it is probably fair to say that its inability to get clearance for policy decisions from the Office of the Administrator of HSMHA, the Office of the Secretary, the Comptroller, and the Office of Management and Budget as well as the shift to regionalization and the resulting divided and fuzzy lines of responsibility had much to do with creating the problems for which the operating agency is now criticized.

I would want to stress, at this point, that I, or we, do not have a particular bias as to the most desirable form of organization for the family planning program, or any other program. Certainly knowing the difficulties inherent in running a moderate size office, I am sympathetic—and even humble—in regarding anyone's attempt to manage a small part of DHEW. However, if we do not have a clear plan for what should be done, we know enough from our collective experience with this particular program to know what should not be done, because it will not work. Furthermore, I believe that other health programs involved in the reorganization are probably not fundamentally different, and that the same observations may well apply.

There are three areas which give us particular concern in regard to the new organization plan. The first is simply the number of persons who will be specifically assigned to categorical programs. Even if we assume for the moment, and this is not proven, that the former NCFPS staff may have been somewhat inefficient, it is difficult to imagine that one-tenth as many people would be able to handle the same job.

It is anticipated, of course, that the five staff members who will make up the Office of the Assistant Bureau Director for Family Planning will have access to various specialized pools to obtain certain types of technical assistance. I would submit that the demands on such a small staff—from the regional offices, local programs, the

Congress, the press, and the general public—would be such as to leave little or no time to formulate what information or assistance needs to be obtained and from whom, to prepare the necessary paperwork and to followup the requests through channels.

In addition, it is unclear how priorities for staff assistance would be determined. Under this system, it is probable that the individual interests or professional priorities of the various assistance units would tend to become paramount in deciding who and what gets attention, in what order or time sequence. This arrangement would tend to encourage internal lobbying and bureaucratic jockeying as assistant bureau directors compete for staff resources to meet their own program needs. It would tend to encourage, rather than discourage, unresponsiveness and unaccountability.

If the headquarters staffing appear insufficient, the regional staffing pattern—which is crucial in a decentralized system—is totally unrealistic. Although no firm decision has apparently been made in this regard, it appears that a table of organization would be put into effect at the regional levels in which all staff would be distributed in four units—standards, services, manpower, and financing, and that one person would be assigned in the services unit for family planning. This person would no longer report directly to the regional health director and would no longer have any supporting staff.

Let me give you a concrete example of what this might mean. The southeast region of DHEW has the largest number of low-income women in need of family planning services in all 10 regions. Consequently, it receives the largest allocation of Federal funds—or close to $20 million in fiscal year 1973. A professional family planning staff of six reviews grants applications, makes site visits, monitors the program and provides them with technical assistance, prepares a regional plan and determines priorities for development, assists communities in developing new or expanded programs, collects program data and other information and formulates policy recommendations or queries, for the Washington headquarters. The size of the job suggests that the program, if anything, is understaffed.

Recently, the press widely reported a lawsuit in Alabama involving the sterilization of two minor girls, perhaps mentally retarded, by the Montgomery County Community Action Agency. This, by the way, is one of the programs in the process of transfer from OEO to DHEW. The investigations which have resulted from this serious incident have occupied most of the staff for weeks. It is inconceivable that one, or even two staff members in the entire southeast could ever have the capacity to provide specialized monitoring of program standards so as to prevent the occurrence of such incidents in the future, or to insure the provision of high quality medical services to the 50,000 men and women currently served in the region.

Such matters cannot be handled by a pool of technicians thrown into whatever situation the daily requirements may dictate. A knowledge of the past history of the project, its problems, its successes and failures, its personnel, the environment in which it operates all have a bearing on preventive or remedial action.

While the one program staff person is engaged in monitoring existing programs, who would, at the regional level, be able to identify areas of unmet need, stimulate community interest, assist local institutions in developing programs, and seeking funding? I would suggest that under

this arrangement it would be difficult, indeed, for new programs to get started and only the most sophisticated grantees would be able to find their way through the maze.

Since the DHEW fiscal 1975 document recently released by Senator Kennedy indicates that while waiting for national health insurance to become a reality, the Department does not intend to allow any growth in family planning project grants or other programs, it may be that the reorganization plan is ideally suited to this funding strategy.

The second major difficulty with the new table of organization resides in the reporting lines. Formerly, the Regional Health Directors reported to the Administrator of HSMHA. The Regional Family Planning Directors reported to the Regional Directors, but depended heavily for program direction and support on the National Center for Family Planning Services. This ambiguous arrangement created a number of difficulties which are bound to be magnified if the Regional Health Directors are to answer directly to the Office of the Assistant Secretary. It is not only the physical and psychological distance between DHEW north and Rockville which will make even ordinary transactions more difficult, but the reporting lines will be so extended so as to make simple decisionmaking interminable. To function effectively, the Office of the Assistant Secretary for Health is bound to develop its own program support units and this, in turn, is bound to duplicate and conflict with the functions of the Health Services Administration.

Lastly, programs and agencies are run by people and their talents, interest, devotion must be taken into account. Their being civil servants does not deprive them of individual and professional concerns which are not always interchangeable. Some choose to work with migrants, some with children, others with the elderly. Staff morale and expertise are important components of the success of a program. The dramatic growth of the family planning program in the last 4 years, to 2½ million patients served in fiscal year 1974, was fostered by greatly increased financial support from the Federal Government, but also by the enthusiasm, devotion, energy, and capability of the staff of the national center and the regional family planning staffs. In spite of some acknowledged bureaucratic weaknesses, the program accomplished what the Congress and the President had proposed and that, after all, may be the supreme test of good management.

The result of this year's events are: DHEW's opposition to the continuation of categorical grant support, its requirement that programs become self-sustaining through medicaid and title IVA while pressing for drastic controls in the utilization of these financing mechanisms and now the uncertainties and anxieties which have accompanied the reorganization plans, have been to stop the momentum of a program in which patient enrollment had grown at the rate of 30 percent a year for 5 years and 38 percent in fiscal year 1972. Since no one has suggested that the program failed to meet its goals, since it is acknowledged to be cost effective and since it has proved enormously popular with patients and the general public, it is no wonder that the family planning staff of DHEW is now totally demoralized and the local programs feel bewildered and betrayed.

We have expressed our concern repeatedly to the DHEW leadership from Dr. Edwards on down, apparently to no avail. We turn to Congress to rectify, or at least to modify, policies which are damaging

to the health of programs and, indeed, to the health and welfare of the American public.

Mr. ROGERS. Thank you very much for a very strong statement. Dr. Cornely?

STATEMENT OF DR. DONALD A. CORNELY

Dr. CORNELY. Thank you, Mr. Chairman. I am Donald Cornely, representing the American Academy of Pediatrics and its 14,000 pediatricians. We wish to express concern to you about program operations rather than reorganization per se, and also the issue of accountability. Quite candidly, I would have preferred to discuss this more thoroughly within the administration to develop more effective programs, but that has not been possible under the circumstances of reorganization.

I would like to have you understand that our judgment is based on somewhat limited information, but that is about the extent made available to us by the administration, but we are also concerned about the manner in which the administration has conducted this reorganization which we believe threatens its credibility to some extent.

If I can use an example, we are particularly concerned with the program with which we are more familiar, maternal and child health, a program for which Congress annually appropriates a quarter of a million dollars. We are simply saying to you that there is a threat to the capacity of the administration, we believe, as we perceive the administration reorganization to carry out this mandate of Congress.

The director of that program, Dr. Lesser, resigned in protest. Dr. Lesser, having been with the program for 32 years and having been through as many reorganizations as there are years in some of us, certainly can't have his action conceived as some frivolous action of a prima donna bureaucrat. He has been through many different agencies in Government, but his resignation was because the program was being dismembered, not simply because it was being assigned to a different supervisor.

We find it a little bit discouraging to wonder why, in the face of substantive disagreement from their own senior staff, there wasn't some attempt made to call at least a temporary halt to the reorganization to study that disagreement. For example, for some modification of it.

You heard this morning that Dr. MacLeod resigned in somewhat the same context. We, for example, are unaware of any administration proposal made to Congress or any congressional mandate to approach the use of appropriated resources to serve unspecified programs. Rather, very specific programs are proposed.

Congress has mandated specific programs. Thus, we do not believe it is sound administration, much less permissible, to utilize resources to have one program to serve the needs of other programs; to allow one program to have direct control over those resources which have been justified by the budget which has been proposed by the administration for which Congress then made the resources available.

If the administration wants to ask for somewhat more generic moneys so it can be discretionary, let them so propose it. That has not been proposed, and we therefore think that is not sound administration.

I would also emphasize that we are not discussing requests for more money but, for example, many things fall between the cracks when

people who are unfamiliar with some of the content of the program are now placed in a position of making policy decisions. Let me give you an example. Last month Congress extended certain specific projects of title V for another year. In anticipation that these were going to expire, the administration proposed a deletion of 53 budget positions but said, "Leave the money there because we will need the money for such things as severance pay."

As yet, there has been no proposal for the administration to restore those 53 positions. So those are the types of inadequacies that occur when people unfamiliar with the program come in to exercise it.

I would also wish to call your attention to the fact that we are unaware of any western country which has approved such things as Congress is now considering, such as health insurance, who has found it possible to have less than a strong Federal level of a program for mothers and children.

That is because you are going to have either of these concepts become administrative if mechanisms by which money is distributed that you can accomplish this with a weakened program such as maternal and child health. We cannot perceive, from the administrative chart made available to us, how they can account to you for what they have done and how you, on the other hand, can find out whether or not the purposes for which you have mandated money have been mandated to the people.

We would suggest that you consider this recommendation, that language be considered by this subcommittee, perhaps in the appropriations bill, which would assure direct operations funds for maternal and child health are utilized for personnel directly responsible and accountable to the program director. In this fashion, we believe it will be focusing upon maternal and child health needs and programs mandated by Congress.

Thank you, Mr. Chairman.

Mr. ROGERS. Thank you very much, Doctor, and we will pursue some of your suggestions.

Mr. Nelsen?

Mr. NELSEN. You just mentioned that you couldn't determine what the Department meant because all you had was the chart. Yet you have a positive statement.

How did you arrive at a positive statement when, on one hand you say you can't determine it, yet on the other hand you have a statement as if you have the whole pattern. How do you arrive at that kind of a conclusion under those circumstances?

Dr. CORNELY. Because one is left to draw the inferences from what one sees on the line chart, Mr. Nelsen. For example, if you look at the line chart under community health services you will see six program directors and all of their staff, but five or six per program director are now displaced into five or six offices. We cannot perceive from that chart how that program director is going to have any control over the staff which has been appropriated for carrying out the functions of those programs. Conversely, we can't see how this staff are accountable to any of the six program directors.

Mr. NELSEN. In the testimony of Mrs. Rosoff, on page 2, you refer to the fact that you found yourself unable to expend the funds appropriated for the program by the Congress. Now, this refers to the past tense.

Mrs. ROSOFF. To the past.

Mr. NELSEN. Well then, really by that statement you are admitting that we need some planning, are you not?

Mrs. ROSOFF. No. I was referring to the form of organization which was in existence before the form of organization which has just been disbanded. It was the step before that, and that the National Center for Planning has been created to do away with that type of problem. That is the agency which has now been abolished.

Mr. NELSEN. I assumed that things in the past had not been the way it ought to be, and there must be a reason why we need some more clarification. I presume that is really what you are searching for.

That is all the questions I have at this moment.

Mr. ROGERS. Dr. Roy?

Mr. ROY. I would like to direct this question to any who would like to answer.

Do you feel that the HEW regional offices are more susceptible to political influences than the central program offices?

Dr. CORNELY. Yes, I would be glad to venture an agreement with the statement, being mindful of the testimony which I know you already heard from Dr. English. I think the problem is greater than just that the vagueness with which the administration within the professional groups are utilized is a concern at the regional level. But who decides what the regional director of the office, where he puts his emphasis, is not apparently a programmatic decision made by professionals as far as we can determine.

Mr. ROY. I have no further questions.

Mr. ROGERS. Mr. Nelsen?

Mr. NELSEN. I don't know that I do at the moment.

Mr. ROGERS. All right.

What if a medical school, Dr. Copper, wants a special projects grant or maybe a waiver of enrollment assistance in developing educational programs for students who want to practice in HMO? What would happen with this new regional concept? Would you have any idea?

Dr. COOPER. Well, I don't think it is very clear yet exactly how we will operate. Apparently the contract will be made with the regional office and it will either operate under some general kinds of national guidelines or will have considerable authority within its own area to make decisions about where emphasis is placed. We have had meetings involving some regional operations already in effect, at which a letter written by the regional director was read and was disavowed by a representative of the national group who was there. It is a question how this thing is going to be anything except a very chaotic situation and one which will not advance national programs in health. We are concerned that we will have a dismembered and uncoordinated kind of development which we think will not effectively use the all-too-few funds which the Federal Government is putting in health programs. It will increase the cost of the bureaucratic administration of these programs, and we will not end up with a sounder national health policy than we have now.

Mr. ROGERS. Well, would you think these regions would have the expertise, for instance, necessary to assist health professionals?

Dr. COOPER. No sir. As has been pointed out, I think by Dr. English, and as I have pointed out briefly in my discussion, there have

been a great number of people who have been ordered to leave the central offices of the various agencies and go to the regions who have refused to do this because of their feeling that there will be an inability to carry out their professional responsibilities and achieve their professional goals. It is difficult, as both Dr. English and Dr. MacLeod said this morning, to attract high-level health professionals into the Federal Government, because of the salary ranges; and because of some of the disadvantages, the lack of freedom of action. Certainly this is magnified tremendously if one tries to repeat this in each region of the country. We see in other areas where regionalization has occurred that the quality of the decisionmaking in the region is not equal to that which we have seen at the central level.

I think Dr. Jacobi has pointed out it has been important to have interaction with the professional staffs at the national scene, nursing and dentistry and the others, to try and get at the best overall program for the health. Where this is fractionated and the regional programs will not have this interaction, we think there may be decisions, as Dr. Jacobi has pointed out, made without the real input of adequate professional advice.

I would also like to emphasize what I think was made very clear by Dr. English this morning, and by Dr. MacLeod, that we are concerned about this dumbbell-shaped staffing pattern which is developing in the Department, where those agencies which have had the professional excellence and the ability to measure and to plan and recommend policy in particular areas, will no longer be there.

We will have a very large staff in the Assistant Secretary's office and a very large staff in the regions, and in between we will have very little. This is a very serious concern. It would affect very seriously the programs.

We have already had, as I said, what we feel are instances where the agencies now no longer have an input into the development of the policy in the Department. Instead, they are looked upon more as just administrators of policy that is sent down to them rather than as being able to participate in the development of that policy from their own particular view.

We agree with the strengthening of the Assistant Secretary's office, but we really feel that his job is an orchestration job. A monolithic kind of organizational pattern here will be deleterious for health.

Mr. ROGERS. Dr. Jacobi, has the Division of Nursing been upgraded or downgraded in the reorganization?

Mr. JACOBI. Well, that is not clear at this particular time. Certainly we would opt for a strong division as we have in the past. This is not to say that some changes are probably not required at this time, but that we do need a strong centralized unit to relate to, to bring our needs to a group that understands the issues, nursing's needs, our emphasis, and so on.

Mr. ROGERS. I notice that you mentioned in Child and Maternal Health that 53 positions have been abolished.

Dr. CORNELY. Yes.

Mr. ROGERS. And when the Congress passed the extension, the law, you would have thought that would have required that change to have been rectified.

Dr. CORNELY. Well, it is my understanding that the administration is responsible to come before Congress with a proposal to reestablish

those, but nothing like that has been forthcoming, even though the money was never deleted from the budget. Now that the law has not been expired or extended, it seems that the positions should be re-established, and the administration has not proposed that.

Mr. ROGERS. Could you let us have a memo on that?

Dr. CORNELY. I would be glad to.

[The following letter was received for the record:]

AMERICAN ACADEMY OF PEDIATRICS,
Evanston, Ill., August 3, 1973.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on Public Health and Environment, House of Representatives, Washington, D.C.

DEAR MR. ROGERS: At the time of our testimony before the Subcommittee on Public Health and Environment on Tuesday, July 31, 1973, you requested that the American Academy of Pediatrics submit a memorandum on the topic of the 53 positions which must be restored to the FY 74 DHEW budget in support of the Maternal and Child Health Program authorized under Title V of the Social Security Act.

In the Administration FY 74 budget document, 53 positions were deleted in anticipation of the expiration of that portion of Title V legislation dealing with special project authority. No reduction of funds for these positions were requested, merely the positions. In the latter days of June 1973 Congress extended this authority along with several other specific pieces of health legislation. Inasmuch as the services are being continued, the 53 positions must be restored to the budget. To date, the Administration has not taken this initiative and we appreciate the Subcommittee taking the steps to assure this needed readjustment to a personnel complement of 132.

May I also reiterate the other recommendation the American Academy of Pediatrics offered the Subcommittee at the time of our testimony. "The Subcommittee on Public Health consider introducing language, perhaps in the Appropriations Bill, which would assure direct operations funds for specified health programs are utilized for personnel directly responsible and accountable to the program directors of such health programs."

It may be that the appropriate course of action for your Subcommittee would be consideration of amendatory language to the Public Health Service Act to assure that each of the authorized, categorical programs be administered by an identifiable administrative unit, with the program direct operation funds being utilized for personnel directly responsible and accountable to the director of such program. Perhaps an agreement can be consummated with the Ways and Means Committee whereby any such amendment would include the Maternal and Child Health Program.

The adoption of these recommendations, we feel, will assure that identifiable administrative units will be focusing on the specific health needs and programmatic efforts to meet those needs consistent with the legislative mandates of the programs.

On behalf of the American Academy of Pediatrics, I thank you for the opportunity to discuss these issues with the Subcommittee on Public Health and Environment, commend you for your initiative in conducting oversight hearings, and solicit your continued support for strengthening health programs.

Sincerely yours,

DONALD A. CORNELY, M.D.
ROBERT G. FRAZIER, M.D.
Executive Director.

Dr. CORNELY. There has been some experience at HEW with decentralization which has been scandalous. About 1967, within the Social and Rehabilitative Services, they attempted for 1 year to decentralize the operation of services training and research, and it was chaotic. The training and research capability in the regional offices—that staff wasn't there—and I think it is delusionary myself to believe that certain kinds of educational ventures are regional enterprises. They are not. I don't believe a university, for example, prepares people just for a region.

Mr. ROGERS. Are there any other comments?

Dr. KERR. Mr. Chairman, we have seen a unique experience in dentistry where a properly organized action program established by the Division of Dental Health working through the regions has been very effective. This is why we plead so much to retain that little visibility so there can be a good organizational functional arrangement of policy planning, program planning, and regional action, which brings that action then to those of us out there in the various communities.

Our concern is that if we lose our identity, if we lose this very effective Division of Dental Health, as I am sure the chairman knows, we will lose strong professional people who are motivated for action not only in Washington but in Endicott, N.Y., where I come from. Of course we have never had the privilege of being able to sit in on the making of policy that relates to $235 million worth of annual Federal expenditures in the dental area, and see that it is coordinated. So we ask for representation in the Assistant Secretary's office. We understand what Dr. Edwards wants and we want to assist him in whatever way possible, but we have never been able to reach that point where we can review not only financial action but, more importantly, what it does and what it means throughout the Nation.

Mr. ROGERS. May I ask this: Have any of you been concerned with programs which were to be reduced or phased out which were subsequently affected by the laws, the 12 extensions? Have you seen any change in policy as a result of the law? Has there been any reaction?

Mrs. ROSOFF. The only reaction has been a sort of mechanical one which is to assume there will be some money for project grants for the coming year. The reorganization, however, I think, has to be looked at in the context of the administration's funding policies.

For one thing, I think we should make clear there are two types of programs were represented here, programs about to be regionalized and programs like family planning and child health which have been regionalized for some time. So we have some experience with regionalization. It hasn't all been bad. What has been bad, and is, that you tend to have 10 policies instead of 1 policy. In this case, the field involved was small enough, and the agency was young enough and cohesive enough that it worked fairly well because they just talked to each other. But this is not exactly a system of management; this is a system of friendship. This would hardly work as well in or for other areas or for a long period of time. What is intended with the new reorganization is to make it impossible that anyone would know anything about the functioning of a program or be in any way attached to it.

This is a way of essentially saying: You report to a pool, and this is the way the work is assigned from now on. This arrangement makes it very certain that, since no one will be attached to the program, no one will fight for the program and therefore no one will have to spend much money. I think this is part of the overall pattern of the DHEW funding strategy. It is not a mechanical thing of playing with administrative boxes.

Mr. ROGERS. Any other questions?

Mr. NELSEN. I have none.

Mr. ROY. I would like to ask just one, Mr. Chairman.

Is my understanding correct that each of you feels that the decentralization and decategorization parts of the organization plan are inadvisable?

Dr. CORNELY. I feel that way.

Mrs. ROSOFF. Absolutely.

Mr. ROY. Now, having said that, and knowing of course that we have wise and experienced men and women in HEW and the Government, could you give me any explanation as to why the Department of HEW is going forward with this decentralization and decategorization of programs?

Mrs. ROSOFF. I suppose I have given one.

Mr. ROY. Yes, I think your previous statement was in response to that. Anybody else?

Dr. CORNELY. I presume they presume it to increase efficiency and effectiveness, and we would applaud that purpose, but it doesn't seem to be consistent with reaching that purpose.

Dr. KERR. Decategorization is probably based on a fine concept that health is a total umbrella. If you start categorizing then you tend to have all five of us fighting for our segment. Conversely, in the development of any organization we would like to hope that we would, as in the private enterprise system, work together for the better health of the patient. We have heard for many years why they didn't want dentistry to be categorized and we have had this discussion constantly over these past years. And, we fully believe, as I said in my presentation, that dental health is an essential part of total health. But, we always lose the visibility when we are placed in a management situation where someone doesn't understand the need.

The development of PSRO's, involving a million people a year who are admitted to hospitals for dental reasons, is an example of a place where we need input at the policymaking level. So it has been a constant battle throughout my professional life to retain this visibility.

Dr. CORNELY. I don't find anything wrong with the thrust. I do find fault with the specifics.

Dr. COOPER. I think we have moved the boxes around again. Our concern is that we stop moving boxes around and get at what really are the critical matters which are the appropriate professional and professional attachments to programs, and the input, develop policy on the departmental level of those who have an interest, knowledge, and ability in the particular areas, and it is the Assistant Secretary's responsibility and the Secretary's out of that, to come out with a departmental policy. But we think it can't be developed in a vacuum.

Mr. ROY. Thank you for your testimony.

Thank you, Mr. Chairman.

Mr. ROGERS. Thank you very much. The committee appreciates your presence here today and the testimony you have given.

The committee stands adjourned.

[The following statements were received for the record:]

STATEMENT BY J. GORDON BARROW, M.D., COORDINATOR, GEORGIA REGIONAL MEDICAL PROGRAM, ON BEHALF OF REGIONAL MEDICAL PROGRAM COORDINATORS

It is the opinion of the majority of the RMP Coordinators that the increased staffing and resulting strengthening of the office of the Assistant Secretary of HEW for Health could result in more efficient decision making capability so that health decisions could be increasingly delegated to this level by the Secretary of

HEW. The Assistant Secretary's office could then more effectively serve as the focus for the health related decisions of the Administration.

Program decisions made by knowledgeable professional program personnel have in the past been much more effective than those made by management personnel without intimate program knowledge. Where management staff have made these program decisions, they have resulted in eventual waste of the federal dollar since decisions have been made without full realization of their potential program impact.

If the decision should be made by Congress in the future to create a separate Department of Health with its own Secretary, this increased capability could certainly lead to a smoother transition than from the present arrangement.

During his testimony before the House Subcommittee on Public Health and Environment, the Assistant Secretary for Health has referred to a possible lack of trained technical and professional personnel as hampering the functioning of the reorganization at the Regional Office level. The RMP Coordinators would like to confine our comments to this aspect of the reorganization, namely the efforts to decentralize more authority to the regional offices.

Technical and professional assistance, a convening capability, close contact with the state provider segment—both state agency and private providers—and expert technical review capability are needed in each state served by the HEW regional office in order to effectively implement the various federal health initiatives. Federal employees newly assigned from Washington cannot provide these functions without long and extensive local contact.

The RMP organization in each state is in position to provide a competent source of expertise for each of these functions, and would be in position to offer assistance to the Regional Office immediately, if desired.

The local provider contacts of the RMPs have already proven invaluable in such areas as the implementation of Emergency Medical Service, Area Health Education Centers, and improved primary medical care.

As well as continuing to be effective in these areas, RMP could play a key role in assisting in the state-wide implementation of specialized services such as heart disease, cancer and kidney control activities of the National Institutes of Health as well as in the rapid and effective implementation of Professional Standards Review Organization and other quality assurance programs.

It is therefore the purpose of this testimony to point out ways in which the reorganization would be made to serve the intent of Congress and the Administration more effectively by utilization of a local arm of the federal health effort—the RMP—to facilitate the more effective local implementation of the various programs, particularly as they relate to the potential role of the Regional Offices and NIH in these local efforts to improve health services.

It should be pointed out, however, that effective capability to perform these local functions is essential if the decentralization concept is to be effective. If decentralization is continued without the capability to perform these functions, it will prove unworkable and would be better left at the program level in the Public Health Service in Washington.

Statement of National Council of Community Mental Health Centers

Reorganization of NIMH

The National Council of Community Mental Health Centers proposes that all the responsibilities now vested in the National Institute of Mental Health be placed in a new agency along with the functions of the National Institute on Alcohol Abuse and Alcoholism and those of the NIMH Division on Drugs. The new agency (a sixth agency within the scheme of the recently reorganized health services) should be called the Administration on Alcoholism, Drugs and Mental Health (using alphabetical order of names).

The three entities within the Administration would be separate Institutes—the Institute on Alcoholism, the Institute on Drugs and the Institute on Mental Health. The three should be co-equals, each run by a professional with particular expertise in the field. The new agency should be administered so as to ensure no particular bias toward any one or more of the program Institutes.

All functions of NIMH—namely services, training and research—should be kept together in the Mental Health Institute in view of the crucial interrelation of the several functions.

Alcoholism, Drug and Mental Health services should be coordinated within the structure of a single agency because of the strong impact they each have on the other and the commonality of the various problems and programs. The principal thrust of all the programs should be two-fold: preventive and rehabilitative.

Part of the objective of the reorganization should be to solidify the role of the Federal Government as having a responsibility for the delivery of mental health services within a scheme that advances the community mental health model. The categorical grant program is not the only way to assure this role, and indeed as soon as a superior system of financing is devised and implemented, the CMHC categorical grant, except for C & E grants, should be phased out and the financing of services to those who otherwise can't pay for them should be taken over by the new system—perhaps a system of national health insurance. But the federal responsibility now existing under the categorical grant program should be maintained until linkage can be achieved with the new financing mechanism.

Also important is the maintenance of the community mental health system as a model for delivering health and social services, namely the linkage with other community facilities and services. To create an administrative environment that would permit the dismantling of the community mental health centers program, after years of effort and investment, would be wasteful of federal dollars. More important, however, it would deny the system builders of a model needed about which to fashion the new system—one which will effectively interrelate all health and social services and ensure that people get the kind of connecting services needed.

The Federal government has a prime responsibility for establishing, financing and causing to be effectively administered a national health delivery system, one that encompasses the spectrum of services from prevention to treatment to rehabilitation, and the development of supportive functions, such as training.

Concerns have been expressed by Alcoholism that it should not be coupled with Mental Health in any new scheme, but should be lodged in a Substance Abuse agency along with Drugs. This concern stems from what Alcoholism considers (and rightly so) being ill used by Mental Health as part of its mental health effort to accomplish the goals of its program. Also, Alcoholism apparently believes that the program thrust of Mental Health—the establishment of a nationwide network of 1500 centers; separate facilities not necessarily integrated (according to Alcoholism) with other community health services—is antithetical to the program thrust of Alcoholism. That thrust, briefly, is the establishment wherever feasible of community programs, preferably as part of existing programs providing other services.

The two thrusts, however, are not incompatible or irreconcilable. Indeed, it is a principal objective of Mental Health to have mental health services integrated into all other community health and social services. Often (usually) the community mental health center serves as the focal point for these integrated services. But there is nothing to prevent a non-mental health agency from receiving a grant to supply services under the Community Mental Health Centers program, and many have. Some are general hospitals, others are social service agencies and some have even been alcoholism or other specialized agencies.

Within the administrative set-up of the new agency, it will be important to institute safeguards which would ensure the integrity of the various programs while at the same time ensuring that past abuses are not carried forward. It is also important, however, to institute safeguards which will assure a federal role in these areas, and prevent the present Administration from carrying out its avowed objective of dismantling part of the mental health program.

[Whereupon, at 3:25 p.m. the committee adjourned.]

APPENDIX

Review of Programs and Organization of the Health Services and Mental Health Administration

(A Report Prepared for the Assistant Secretary for Health, April 5, 1973)

I. STUDY PERSPECTIVE

On February 21, 1973, a special work group was convened by the Assistant Secretary for Health who delivered the following charge:

". . . undertake a broad review of HSMHA's programs and organization, and their interrelationships with the other health agencies."

". . . submit to the Secretary, by April 15, 1973, an organization plan which will: (1) reflect recent and projected changes in the programs administered by HSMHA; (2) be designed to help achieve the Department's goals in the field of health services with maximum management effectiveness and efficiency."

1. Extensive interviews were conducted

Also explicit in the charge was the desire to achieve broad input into the study through extensive interviews. During the course of the study, more than 80 officials and staff inside and outside HSMHA were interviewed by the task force. The list of interviewees is shown in Appendix A.

2. The appropriate Federal role in health provided the basis for the organizational analysis

The appropriate federal role in health has been summarized in recent statements by Secretary Weinberger and Under Secretary Carlucci. This role is:

(1) *Financing of Health Services* to reduce financial barriers affecting access to health care. The current vehicles for accomplishing this are Medicare and Medicaid. A more comprehensive approach to national health insurance is likely.

(2) *Health and Medical Research* activities that have broad national benefits but whose high investment costs make it difficult for the private sector or State and local governments to make an adequate annual investment.

(3) *Preventive Health and Consumer Protection* activities that can be achieved best through collective action, such as regulation of the manufacture and sale of foods, drugs, and medical products; and preventive health and safety activities, such as the control of communicable diseases.

(4) *Limited Technical Assistance and Special Start-up Funding for Demonstration* of structural changes in the system, to introduce new types of facilities or manpower, or to demonstrate new types of delivery systems.

(5) *Health Manpower Education Programs* as part of a general educational initiative that will place principal reliance for accomplishing this role on the institutions of higher education with Federal support through general student assistance programs administered by the Office of Education. Limited Federal assistance may be needed to overcome especially difficult supply and geographic distribution problems, or to demonstrate the validity of new types of health professionals.

(6) *Direct Provision of Health Care Only as a Last Resort.* The Federal government's responsibilities to provide health and medical services directly to certain population groups, such as reservation Indians and merchant seamen, will continue until these groups are provided for adequately under other mechanisms.

3. The study had to be broadened beyond just the health sector of DHEW

With the study requirements to reflect actual and projected program changes and achieve the Department's goals in the field of health services with maximum management effectiveness and efficiency, the scope of the study could not be limited to programs within the NIH, FDA, and HSMHA. Major decisions have been

made by the Administration that have widespread impact and implications beyond the present health services organizational structure. Therefore the issues identified and recommendations developed cut across agency lines.

II. STUDY FINDINGS

The findings in this study fall into three general categories: tbose impacting health services across agency lines; those dealing with the HSMHA organization as presently structured and those pertaining to regional operations.

1. Health care financing programs need to bc developed and administered in the context of a total health strategy

Medicare and Medicaid together represent the largest single Federal influence on the nation's health care delivery system. Together they pay for almost one third of the inpatient hospital bills in the U.S. Expenditures for these programs are estimated at $17.4 billion in 1974, or almost 80% of the HEW health budget. Because of their uncontrollable nature, outlays for health financing and their share of Federal health outlays can be expected to increase.

An important factor in the rapid rise in health care expenditures is the failure to achieve changes in the supply and organization of health services that are consistent with the increased demand generated by the availability of financing. Because of the impact financing programs have had on inflation in health care costs, new methods are being devised to attempt to utilize Federal financing programs to contain these rising costs. In line with these efforts, increased attention needs to be paid to problems and inefficiencies of providers and to financing decisions that affect provider activities and costs. In addition, plans and programs that affect the financing of health services need to be integrally related to activities aimed at the development and modification of systems of health care delivery resources.

Currently, the major Federal health financing programs are operated by agencies whose concerns are not the substantive issues of financing insurance programs' impact upon health care delivery, but rather managing large scale payment programs and determining eligibility of beneficiaries. Although some HSMHA programs are attempting to capture third party reimbursement for services, and have provided professional advice regarding standards for participation in financing programs, the health agencies of HEW have not been in a position to significantly influence Medicaid and Medicare. Moreover, the Assistant Secretary for Health, even witb nominal "policy guidance" responsibility for health financing, has not been able to affect the financing programs in an appreciable way.

The effect of a broad national health insurance program upon the nation's health care delivery system will be even more profound than that of Medicaid and Medicare.

It is critically important that the present and future health financing programs be integrated with other Federal health activities.

The following are examples of the integral relationships between future health activities and the financing programs that can be achieved most successfully tbrough single leadership:

Tbe benefit package for national health insurance should be designed with a view toward medical necessity and efficacy of services covered rather than their similarity to other insurance plans.

The continuing supply and distribution of healtb care resources need to be integrated with the demands for services generated through financing.

The development and administration of national health insurance should embody the experience gained from Medicare, Medicaid, HSMHA, and NIH biomedical research in a whole range of activities such as treatments for specific diseases, and efficacy of medical care.

The determination of what constitutes the essential mental health services to be covered under national health insurance should be based on the expertise of NIMH.

The effective development of preventive health activities should consider whether prevention would be accomplished more effectively through coverage of preventive services under financing or through collective action.

Coverage of preventive health services under national health insurance should be based on the experience of HSMHA as to their efficacy.

Reimbursement of Federal service projects through national health insurance can be accomplished much more easily and quickly under single leadership that could mandate, for instance, reimbursement of free-standing

clinics under Medicaid or reimbursement of NHSC personnel by Medicare. There is presently no single focus to effect this integration.

Research priorities for both health services and biomedical research should be developed with a view toward the health problems encountered through the financing system.

Economic considerations of providing and influencing distribution of health resources through reimbursement policies need to be fully explored.

These examples illustrate major issues in Federal health programs that can only be fully explored and resolved if all health programs are considered integrally and if the financing programs are fully utilized to determine the outcomes. Such issues can most successfully be resolved by consolidation of all HEW health programs, including financing programs, under single leadership and responsibility.

The present operations of health financing programs are not integrally related to the other program activities within SRS and SSA. Both MSA and BHI receive administrative support and overall policy direction from their parent organizations. Eligibility determination for Medicare is the only function that would have to be maintained within the current context of the income maintenance programs, but it could be performed on a service basis by SSA, with reimbursement from the operating health agencies as appropriate for the services provided.

In the case of Medicare, eligibility for all social security benefits is determined uniformly by SSA staff, and records of eligibility are maintained centrally in SSA for each beneficiary. Records on utilization of Medicare are maintained by the carriers and intermediaries. Records on beneficiaries' payment of the required Medicare deductible are kept centrally in SSA, but are not a part of the larger record system on social security beneficiaries' utilization of other social security benefits. These activities are routine and do not impact significantly on the health delivery system and could, therefore, be continued in the current fashion and paid for by BHI on a service basis.

The operation of the Medicare program and its payment system are relatively self-contained within BHI. The activities conducted in BHI—the certification of providers for participation in Medicare, contracting with the fiscal intermediaries and State health agencies, and determination of reimbursement policies in terms of reasonableness of cost and appropriateness of care received—are the ones that have a major influence on the health care delivery system. The removal of BHI from SSA would not seriously disrupt either these activities or the other ongoing operations of SSA.

For Medicaid, both eligibility determinations and the payment of individual claims are the responsibility of the States. The Federal functions with respect to both eligibility and reimbursement policy are limited to developing regulations and guidelines. Federal payments to the States for Medicaid are made centrally in SRS, but the operation is a relatively simple one of determining the allowable Federal share of the total States' Medicaid costs. The part of the payment operation in SRS that relates to Medicaid could easily be identified and run by MSA. Although Medicaid admittedly has less influence on the health care delivery system than Medicare, it is the development by MSA of Federal guidelines to the States for reimbursement policy that is critical to influencing the system. In addition, these guidelines need to be consistent with Medicare reimbursement policy in order to achieve the maximum impact on the health care delivery system. MSA could be removed from SRS without disrupting either the Medicaid program or the other operating programs in SRS.

2. The office of the Assistant Secretary for Health will require strengthening and realigning to effectively assume its role as a focal point for establishing and directing health policy

Although the Assistant Secretary for Health has been identified as the principal official responsible for the Department's health policies since April 1968, his office has never been staffed or aligned to carry out this responsibility effectively. Furthermore, he has not been in a position to direct or to be held accountable for the implementation of established policies. The Assistant Secretary, for instance, has budgetary responsibility for only about 20% of the HEW health budget. The result has been lack of an integrated health strategy. The authorities and capabilities of the Assistant Secretary for Health must be enhanced to resolve these problems.

There has been increasing overlap and duplication of staffs and activities between the various health programs of the Department especially in the areas of research, statistics, and financing standards. The current fragmentation of leadership and accountability means duplication and waste of staff as well as lack of any

effective focus for activities that bridge the financing and service programs, such as PSRO's. This lack of focus has resulted in considerable confusion of responsibility and activity not only within HEW but also throughout the private sector which must relate to the federal health financing programs. The Assistant Secretary's responsibilities should be defined so that he can be held accountable for the planning and implementation of all the Department's health programs.

3. The character of HSMHA undergo drastic revision to accommodate the new Federal role in health

The present character of HSMHA reflects the development of a variety of categorical grant programs during the 1960's. It is composed of 16 categorical programs with narrowly defined missions, each operating relatively independently and largely without a clear definition of their relationship to an overall health strategy. These programs and functions must be reorganized and redirected to contribute more effectively to the Department's health leadership responsibilities. New relationships must be established to relate HSMHA programs more effectively with the current health financing programs and to a future program of national health insurance.

4. The respective roles of the health agencies, especially in applied research and control activities, are not clear

Since the establishment of HSMHA and the realignment of the other health agencies in 1968, the major trend in health services programs has been toward the delivery of health services in a comprehensive manner. Biomedical or disease-oriented research has been maintained in a categorical setting. The Cancer and Heart and Lung Disease Acts of 1971 and 1972, however, call for initiation of categorical "control" programs in community settings to expedite the translation of the results of research into medical practice. The re-introduction of categorical service activities in a research setting has confused both the role of research programs with respect to delivery of health services and the role of service programs with respect to comprehensive approaches to service delivery.

In addition, applied research that is ostensibly relevant to many health activities has grown up in virtually every health agency of HEW. The question arises, then, of whether this research is more effectively carried out in an independent research setting, or whether it should be integrally related to the programs it supports.

6. The role and organizational placement of the health manpower programs needs to be redefined

The health manpower development activities of the Department were organized in a Bureau of the Public Health Service in January 1967. The organization provided policy focus for manpower education; unified management of a number of special educational support programs for health professionals; and a focus for developing innovative methods in health manpower education. The Bureau was moved to the NIH in 1968 in recognition of the overall impact of research and educational support programs on medical schools and institutions of higher education.

Until recently, the programs in the BHME have been concerned primarily with the education of health manpower and have therefore focused on academic institutions. Questions of utilization, distribution, and payment for manpower were considered by health services and financing programs. Most of the health service programs have therefore established separate manpower development activities to address these issues as they relate to their partlcular health service mission.

Federal support for education will be provided primarily through general student assistance rather than categorical support for educational institutions. The budget request for 1974 phases out many of the institutional support programs of the Bureau, while increasing special programs to stimulate development of new and flexible methods to train and utilize personnel.

These activities and the manpower efforts that have proliferated among HSMHA programs need to be combined to eliminate the duplication and confusion which currently exist. A focal point is needed that views the provision of trained manpower for the delivery of health care services as a form of resource development to be undertaken with a view towards its ultimate utilization and reimbursement.

6. HSMHA is a conglomerate of specialized categorical programs without a central purpose supportive of overall health policy. Interprogram communication and coordination is minimal and clustering of programs has been marginally effective in correcting this problem

HSMHA was created in 1968 primarily to bring together all programs concerned

with the provision of health care. It currently consists of 16 separate operating programs, most of which have a separate and unique legislative mandate to address a narrowly defined problem within the health care delivery system.

Viewing HSMHA as a whole, there is a broad range of diverse activities that has evolved as each program established separate components designed to meet its unique objectives. These range from direct delivery of care to technical assistance and basic research. Many of the functions established in the separate programs are similar. Most programs have developed a technical assistance and grants management capability, for instance, and half of the programs have specialized training and research activities.

There have been attempts, through special projects and committees in such areas as data management, third party financing, and services integration to involve appropriate programs and combine resources in a HSMHA-wide effort to achieve a coordinated approach to a particular health services delivery issue. These efforts appear to have been limited in scope and effectiveness to blend HSMHA efforts under a broad health services strategy.

HSMHA planning has traditionally been done on a program-by-program basis rather than in support of agency-wide goals. HSMHA-wide goals have been stated in general terms of improving access, efficiency, quality and effectiveness of health services. This general approach to goals is a best attempt to summarize potential impact of the various programs, but unfortunately these generalized goals have been beyond the aggregate ability of HSMHA to achieve.

In November 1971, HSMHA programs were grouped into four clusters, each under a separate Deputy Administrator. These clusters represented the major areas of activity within HSMHA, namely Prevention and Consumer Services; Health Services Delivery; Development; and Mental Health. (See Appendix B for current HSMHA organization chart.) From interviews with the 16 Program Directors, it appears that where clusters served any purpose it was to improve the interaction among programs but only those within the cluster. Nevertheless, the interviews also revealed that programs within the cluster still duplicate efforts and maintain separate staffs; that the most effective program interrelationships are still at the operating level; and that there is little joint planning, operation and evaluation. Half of the Program Directors felt the cluster had no effect on their program, and four felt the cluster system had even hindered their efforts.

Interviews revealed a variety of perceptions on the role of the cluster Deputy Administrator. Of the responses from the Program Directors, three considered the cluster deputy to be a line manager, four a coordinator, while eight thought he served as both. There was agreement among the Program Directors that when clusters were originally established, the cluster deputy was intended to coordinate programs and act as a crisis solver; but, in some instances, depending on the deputy's personality, his role gradually became that of a line supervisor.

In summary, the clusters appear to have offered a convenient way to conceptualize the broad array of HSMHA programs and to have reduced the direct span of control of the Administrator; but not to have been effective in coordinating program resources to achieve broader health services goals.

7. The interface between health service and health care financing programs has been inadequate

Discussions with HSMHA Program Directors revealed that only a few steps had been taken at operating levels to assure that adequate relationships exist between HSMHA-financed service activities and SSA and SRS financing programs. In addition, the relationship of the health service and health financing programs in the processes of policy development and program planning is not consistent or adequate. As a result, opportunities for an integrated policy with respect to health services have been foregone. Crucial decisions regarding the implementation and operation of a national health insurance program deserve a more thorough and substantive input from the Department's health officials.

With increasing dependence on financing programs for health services, many questions arise from the lack of a coordinated health service policy:

Should grant programs provide a different benefit package from financing programs?

Are some of these services medically desirable, and should they be covered under financing?

What needs to be done to bring the Indian Health system up to standards of participation for financing?

What is the maximum potential for reimbursement of project grant activities through existing and future financing programs?

Answers to such questions are essential to developing a unified health strategy, and they are possible only through a close integration of all HEW service activities.

8. The relationship of mental health to other HSMHA activities is unclear

At the time the Public Health Service was reorganized in 1967 and 1968, NIMH had developed sizable service delivery program elements in addition to its basic research activities. It had become a disease-oriented, vertical organization, approaching mental health problems through a variety of activities. The placement of NIMH in HSMHA in 1968 appears to have made sense as organizational housekeeping and because NIMH had many functions in common with other HSMHA programs. Its size, variety of activities, and single focus, however, make it unique. As NIMH is divested of its responsibilities to finance the operation of community mental health centers and other mental health training and services, it begins to assume the characteristics of the other research institutes at NIH.

9. The new organization must provide for the phase out of major health service activities

The 1974 budget calls for the termination and redirection of several major programs and activities in line with a redefinition of the Federal role in health. A reorganization that looks toward the future roles in health must at the same time provide for the orderly transition of ongoing operations.

Within HSMHA, the Regional Medical Program, the Hill-Burton Construction Program and the Emergency Health Program will be terminated by the end of FY 1974. Support for community mental health centers, alcohol abuse projects and long term training will be gradually phased out beginning in FY 1974. St. Elizabeth's Hospital will be transferred to the District of Columbia, and contracts with community hospitals and other Federal facilities will replace direct provision of inpatient care in PHS hospitals. Project grant support for Maternal and Child Health Service will be replaced by formula grant funding. Although no specific action was requested in the budget, several of the remaining HSMHA programs anticipate significant changes in response to the move toward health services financing and the discontinuance of activities best supported at the State and local level.

In the Bureau of Health Manpower Education, the budget calls for termination of categorical support in allied and public health, and for schools of nursing, veterinary medicine, podiatry, pharmacy and optometry. Funding is increased for special projects and educational initiative awards in order to focus health manpower training support in areas of special need.

10. The current role of the regional offices and their relationship to national programs have not been adequately defined and implemented to reflect the increased emphasis on decentralization

Tensions exist between the regional offices and national categorical programs. The regional offices are generally concerned with helping develop integrated health service systems to meet State and local needs and priorities. On the other hand, national programs are generally concerned with specific objectives under more narrow categorical missions specified in legislation and appropriations.

The integration of these categorical programs in supporting comprehensive health service development has been defined as a responsibility of the regional offices. Recent decisions to accelerate the decentralization of programs to the regions stress the need to place decision-making authority closest to the point of program implementation in order to improve the effectiveness of programs and the coordinated use of all resources in meeting local health care needs.

Decentralization of HSMHA grant programs to the regions has proceeded to the point where 25 grant programs have been decentralized, representing 60% of the total HSMHA grant dollars. Additional grant programs have been partially decentralized while another 20 remain centralized. Most of this latter group have been determined appropriate for centralized operation. Alcohol and drug abuse service grant programs are presently centralized, although decentralization plans are now being developed.

While considerable progress has been made in the decentralization of grant programs, the regions have expressed difficulties in achieving program integration. During interviews the Regional Health Directors stated the following common problems:

There are serious differences between regional offices and headquarters staff with respect to the manner of achieving objectives. Headquarters programs

have viewed some efforts at integration as obstacles to the achievement of national programmatic objectives.

Inadequate integration of programs at headquarters leaves too much responsibility for coordination at the regional level.

The fact that regional offices receive separate allocations tied to individual appropriations instead of a consolidated operating budget is viewed as a constraint to their ability to integrate activities.

There is inadequate structured regional office input into national policy and budget development.

Relations with Medicaid and Medicare staff are generally episodic and unstructured.

11. The role of the regional office needs to reflect the future Federal roles in health

At present, the primary role of the HSMHA regional health staff is to implement and integrate HSMHA's various categorical grant programs within the HEW region. Organization at the regional level is a reflection of Headquarters organization along cluster and categorical program lines. Coordination with the health activities of other agencies is limited in the regions just as it is in headquarters. As the HEW health agencies respond to changes in the federal roles in health, the RO health staff will be expected to assume the following responsibilities:

Awarding funds to and monitoring performance of organizations established to maintain surveillance of professional standards.

Monitoring performance of agencies which have roles in health insurance financing systems.

Certifying facilities for participation as providers in health financing programs.

Providing technical assistance to prepare community-level health care delivery projects for financing through reimbursements.

Providing technical assistance to community or State-level authorities for the prevention of communicable diseases.

Coordinating and assisting in collection of data on health care resources and health status.

Awarding funds for State-wide and community level planning and coordination efforts.

Assisting in the implementation of programs to provide care for beneficiaries through direct delivery activities.

Assisting programs for safeguarding health through enforcement of laws governing the manufacture and sale of food, drugs, and other substances.

III. RECOMMENDATIONS

The recommended agency structure for the health services activities of HEW contains three new agencies organized around the functions of providing and financing health services, development of health resources, and prevention and control of health problems. Within each of these functions, the federal role varies from one of direct action to one of serving as a focus for information and advice. Four other organizational options which were considered are discussed in Appendix C.

Implementing these three agencies would result in a health structure consisting of five agencies, each functioning under a specific health mission:

Food and Drug Administration—consumer protection.
National Institutes of Health—biomedical research.
Center for Disease Control—preventive and public health.
Health Resources Administration—health care resources.
Health Services Administration—health services.

The purpose of this study has been to create a structure that facilitates the development and implementation of consistent HEW health policy. The functions of the three new agencies provide a continuing focus on the elements that will have to be considered in the development of overall health policy.

Since the establishment of CDC as a separate agency requires very little change, the primary elements of this recommendation are to consolidate into two agencies major HEW activities that support the provision of health services and the development of health resources.

Within a new agency for health services, all programs now financing or directly supporting the delivery of health care would be consolidated. The need to bring the major financing programs of Medicare and Medicaid under health policy direction has been discussed earlier in this report. In addition, the current HSMHA

health service programs would be consolidated to facilitate a coordinated approach in redirecting these activities toward support through the financing system rather than direct Federal assistance. These current HSMHA service programs are supported through a variety of mechanisms, including formula and project grants, contracts, and direct federal assistance for beneficiary care.

It is recognized that the effective operation, consolidation, and redirection of these activities will place extensive administrative burdens on a new agency that is also charged with operating and integrating the health service financing activities. Nevertheless, it is strongly recommended that these functions be in a single agency to provide a strong policy focus for health services, to meet the need for more effective interaction between direct service and financing programs, and to eliminate costly and at times conflicting duplication of efforts between them.

The consolidation of activities supporting the development of health care resources is the second major provision. The proposed new HRA will require immediate and extensive redirection and integration of ongoing programs. A greater degree of competence must be developed to provide the surveillance and research activities necessary for development of a coordinated resources strategy. In addition, this agency will require immediate integration of ongoing resource development programs within a coordinated resources strategy. The long term focus of this agency must be the provision of information, analysis and advice on the overall supply, demand, and effective utilization of health care resources.

Resource development has been articulated as a Federal responsibility in the past, and has been the general goal of numerous, scattered efforts. Consolidation of these activities will facilitate more effective utilization of limited Federal funding through greater targeting of activities. Problems should be identified in a broader context of the overall view of health resources in the U.S. The impact of this agency will not depend as much on the operation of direct programs, as on their indirect role in influencing the policies and programs of other agencies.

1. The Health Services Administration will be the focus for all HEW Health Services activities

The primary *mission* of the Health Services Administration will be to provide and finance the delivery of health services through Medicare, Medicaid, grants and contracts, direct delivery, and ultimately, national health insurance. Major *functions* include administering the health care financing programs (Medicare and Medicaid); developing and monitoring compliance with standards for participation of providers in financing; reviewing the appropriateness of care received in terms of cost, quality, and effectiveness; preparing existing health service programs for support through third party financing by strengthening their management capability and ensuring they meet acceptable standards for reimbursement; and providing health services to specific federal beneficiaries while facilitating conversion of these activities to support through financing programs.

The Health Services Administration would include all HEW *health care financing activities:* the Bureau of Health Insurance (BHI) from the Social Security Administration (SSA); the Medical Services Administration (MSA) from the Social and Rehabilitation Service (SRS); the Professional Standards Review Organization (PSRO) and Nursing Home Affairs activities from the Office of the Assistant Secretary for Health (OASH); and Medical Care Standards activities from the Community Health Service. In addition, HSA would include all *service project activities:* family planning projects, neighborhood health centers, family health centers, and migrant health projects; *formula grants:* Maternal and Child Health (MCH) and 314(d); and *direct care activities:* Indian Health Service (IHS) and Federal Health Programs Service (FHPS).

Within this agency, the financing activities might be integrated and organized lnto 3 major components after the BHI substructure. These three financing components would be policy development, program implementation, and program monitoring. The service and formula grant activities might comprise a fourth self-contained component of HSA that has within it functions comparable to the financing substructure. The grant services component could contain a unit for policy and regulations, one for technical assistance and program implementation, and a third for program monitoring. (Training of grantee staffs is considered a form of technical assistance.) The direct care activities might comprise the fifth component of HSA. These activities are relatively self-contained administratively because of their distinct operating requirements, and could retain much of their present organizational structure.

The administrative structure for program direction and staff support ln HSA would be derived from SSA, SRS, and HSMHA. In addition to the integral BHI

and MSA components, certain administrative support functions, such as personnel and financial management, are now carried out centrally in SRS and SSA, and a proportion of those staffs should be identified and transferred to HSA. There are, as well, some policy support activites in SSA that relate to Medicare. The relevant portions of these activities—i.e. sub-units of the Office of the Actuary, Office of Research and Statistics, Office of Program Evaluation and Planning, and the Bureau of Hearings and Appeals—should be identified and transferred to OASH and HSA.

The Health Services Administration will serve as a policy resource for issues concerning the delivery of health services. Information on utilization of all federally-financed health services will be collected through HSA, although all other data-gathering activities will be conducted in HRA. These operational data will include utilization of services through reimbursement, grant, and direct service programs and will need to be closely related to baseline and other data developed in HRA. All research will be conducted in HRA, including research and experiments with the financing system. HSA staff will identify problems with the financing system that have policy implications, and they will work closely with HRA research and surveillance staff to develop experiments that help resolve these policy questions

2. The Health Resources Administration will provide national leadership with respect to the requirements for and distribution of health resources.

The *functions* of the Health Resources Administration will be: providing overall surveillance of the status of health care in the nation through State and local health planning activities as well as collection and analysis of data on resource supply and demand, vital statistics, and disease incidence; developing and testing (in coordination with Federal health service activities) new approaches to the provision, distribution, and utilization of health manpower, health facilities, and health care systems; providing limited special support for development of resources that are not effectively provided through health service financing or general education support mechanisms.

This agency brings together the entire set of HSMHA organizations now located within the Development cluster—National Center for Health Services Research and Development, Health Care Facilities Service, Comprehensive Health Planning Service, Regional Medical Programs Service, and Health Maintenance Organization Service—and the Emergency Medical Services and National Center for Health Statistics from the HSMHA Office of the Administrator. The Bureau of Health Manpower Education from NIH, the National Health Service Corps, and other health service research and training activities that are now located in various HSMHA programs are also brought together in HRA. The Health Resources Administration will require a thoughtful and carefully planned integration of ongoing programs. In addition, a new program dimension needs to be developed to provide a national policy focus with respect to health resources and health data. Consolidating these several major programs will be the first step in creating a strong, continuing organizational capability for health resources activities.

The substructure of the Agency should clearly reflect the continuum of health resource programming: from *surveillance* of what is happening in the health system and its components; to *research* and *evaluation* of specific segments and issues related to the health system; to *development* and *operation* of well-defined demonstrations and limited resource development activities.

The *surveillance* component is envisioned to include the current activities of the Comprehensive Health Planning Service, the National Center for Health Statistics, the manpower intelligence unit in BHME, and current HSMHA activities related to the definition of health scarcity areas. The *research* and *evaluation* component includes the National Center for Health Services Research and Development and the research elements of the BHME and other HSMHA programs. The *development* and *operations* component includes the demonstration and developmental programs of the BHME, the National Health Service Corps, Health Maintenance Organization Service, and Emergency Medical Services; and the operational programs of BHME, the Regional Medical Programs Service, and the Health Care Facilities Service.

It is important to emphasize the need for consolidating *ongoing* research and training activities. Where such ongoing work goes beyond answering the needs of specific grant or contract operated programs, they should be included in HRA. Program direction and management support for this new agency should be obtained primarily from BHME and HSMHA.

3. The center for disease control will be the focus for preventive health activities currently being carried out within HSMHA

The primary *mission* will be to provide national leadership for the prevention and control of communicable and vector-borne diseases and other preventable conditions. Major *functions* will include preventing and controlling communicable diseases by stimulating State and community action, providing technical assistance, and demonstrating effective techniques; developing occupational safety and health standards and other related activities to assure safe and healthful working conditions; administering programs relating to childhood lead-based paint poisoning and urban rat control; directing foreign and interstate quarantine activities; and improving performance of clinical laboratories.

This agency would contain the programs in the Prevention and Consumer Services cluster—Center for Disease Control (CDC), Bureau of Community Environmental Management (BCEM), and National Institute for Occupational Safety and Health (NIOSH). The agency would retain the designation of Center for Disease Control, since the primary agency emphasis will continue to be on the current CDC activities. The lead-based paint and rodent control programs and associated staff which remain in the FY 1974 BCEM budget should be incorporated into the CDC structure, rather than be retained as a free-standing organization. NIOSH, however, should retain its independent organizational status in anticipation of its transfer to the Department of Economic Affairs under the President's Departmental Reorganizational Plan. A careful review should be made of all NIOSH activities prior to transfer to DEA, to determine appropriate activities to be transferred and to establish future program linkages between DHEW programs and NIOSH.

During implementation, special administrative arrangements may need to be made if NIOSH central office staff continues to be located in the Parklawn Building, while looking to the CDC in Atlanta for overall program direction and management support. The remaining BCEM operations could also be accommodated under these special administrative arrangements, if it appears desirable to maintain their present location at Parklawn. It is expected that the combined staffing available for this agency in 1974 will be sufficient to manage the new organization.

4. Other organizational areas will require special attention

Preventive Health Activities

In addition to health services and health resources, the third broad complementary component of an overall health strategy is the function of preventing and controlling health problems. Activities of this type include the consumer protection activities of the Food and Drug Administration, the communicable disease prevention and control activities of CDC, and the occupation and environmental safety and health activities of NIOSH and BCEM.

Consideration was given to grouping all preventive health activities under single leadership in a health protection agency, as envisioned for the Department of Human Resources by the President's Departmental Reorganization Plan. This single agency approach would provide the third aspect of an overall health strategy and would consider broad questions of how to prevent health problems from both a personal health and a public health aspect. Such an agency would serve as a source of expertise regarding the efficacy of various preventive health services that are proposed for coverage under health financing programs. It would also weigh the relative merits of conducting preventive health activities through a public health or collective action approach rather than a personal health services approach.

It was generally felt that consolidating preventive health activities under single leadership would clarify the definition of preventive activities; however it was also recognized that the merger of an enforcement agency with an agency which has relied with significant success on cooperative and technical assistance approaches would not strengthen either agency's ability to perform. Thus, a move to consolidate FDA and CDC is not recommended in this report. The recommendation groups all clearly preventive activities that are currently in HSMHA under CDC leadership, and maintains the separation of FDA.

It is important, in lieu of consolidating enforcement and other preventive activities, to distinguish their functions from those of other health services and health resources. Preventive health activities should be specifically targeted efforts designed to determine and reduce the impact of or avoid exposure to infectious or unsafe agents or conditions that may have a detrimental affect on health. They should not overlap with other more general efforts to increase the effectiveness of the entire health care system, nor should they overlap with efforts

to improve delivery of general (as opposed to preventive) services by State Health Departments. Without a clear demarcation of this nature, activities carried out for prevention may become indistinguishable from other health care services.

National Institutes of Mental Health

Deliberations concerning the appropriate organizational placement of the National Institutes of Mental Health in the restructuring gave consideration to several factors. Primary among these were: budget actions consistent with the new Federal role in health which de-emphasize service delivery and manpower training programs; the resulting emphasis on research as the predominant future role of NIMH; and the functional integration being achieved in the recommended five-agency approach reflecting resources, services, prevention, research, and consumer protection.

There are distinct advantages in considering a functional integration of NIMH, i.e., moving manpower training and statistical activities to HRA and service delivery project and formula grants to HSA. This would achieve a clear consolidation of the health service and manpower programs and facilitate the necessary conversion to other financing mechanisms along with similar activities in the new HSA. It would simplify policy development and implementation for such programs. In addition, the NIMH expertise would facilitate the inclusion of coverage for essential mental health services in the financing programs. Under this approach, the basic research and research training activities would be moved to the NIH.

The NIMH alcohol and drug abuse service activities, however, require legislation to be separated from NIMH. Since feasibility of short-term implementation was an important consideration, the separation of alcohol and drug abuse services from NIMH was not recommended. This decision implies the retention of at least some service activities within what will become primarily a research program.

At the same time, there is merit to placing primary emphasis by organizational placement on the future role of NIMH as a research-oriented organization without limiting its activities to research. This would result in a minimum of disruption within mental health activities, with the possible risk of complicating the future conversion of service and manpower programs.

Given these considerations, it is recommended that NIMH be retained as a free-standing Institute and be placed within NIH. Placement of NIMH in NIH makes it even more important to give attention to resolution of the issues concerning relationships among the health service delivery aspects of NIH programs—particularly those in the National Cancer Institute and the National Heart and Lung Institute—and the proposed Health Services Administration and Health Resources Administration.

Health Service Delivery Aspects of NIH Programs

The interfaces between basic biomedical research, demonstration, and direct delivery are complex. In the specific area of demonstration and direct delivery of services, the most obvious area of concern is the re-introduction of control programs in the National Cancer Institute and the National Heart and Lung Institute.

It was not possible in this study to give full consideration to defining appropriate relationships and operational patterns between health service delivery and biomedical research. Control programs and other health service related activities of NIH with their categorical focus would attempt to bridge from research to services through the establishment of disease-oriented community systems of health care. It was the general assumption of this study that these services must, in the long run, be tied to health financing programs. While no recommendation is being made for organizational changes to address the relationship of service delivery and research programs, the area requires further study and resolution. Legislative, programmatic, and pragmatic concerns should be incorporated into an analysis of alternative steps the Assistant Secretary for Health could take to clarify these relationships. These considerations will have substantial impact on the HSA service delivery program policy and implementation, decentralization actions, regional office program responsibilities, and the future role of research programs.

Applied Health Research

During the study, it was evident that applied research is being carried out in virtually every HEW health agency. Applied research—both biomedical and health services research—is needed to develop means of improving the health service delivery system and preventive health services and to provide a sound

scientific basis for regulatory action by FDA. This research was initially the responsibility of NIH, but has grown up elsewhere largely because the NIH research has been unresponsive to other program needs.

Environmental health research is probably the most diffuse area of applied health research. Within HEW, environmental health research is carried out in NIH by the National Cancer Institute, the National Institute for Environmental Health Sciences, the National Institute of Child Health and Human Development; in FDA at the National Center for Toxicological Research; and in HSMHA by BCEM, NIOSH, and CDC. The primary need for this research is as a scientific basis for FDA's regulatory decisions, yet most of the research other than that at NCTR is not influenced appreciably by FDA's needs.

In addition, the applied research problem includes much research that falls into the "gap" between NIH and HSMHA. This research would be useful both to the financing and delivery of healtb services and to the development of health resources, but NIH considers it too service- or technology-oriented and HSMHA considers it too biomedical-oriented. This research could be made more responsive to the program needs either by placing it organizationally within the program that would use the research results, or by establishing a mechanism for the program that needs the results of the research to influence the priorities for and the ways the research is carried out.

It was recognized that neither of the two possible solutions to the applied research problem was happening in HSMHA. It was also recognized that the solution to the environmental health research problem probably did not lie in HSMHA, since the problem concerned primarily FDA and NIH. To attempt to address that problem through an applied health research organization in HSMHA would tend to complicate rather than simplify it. While the problem requires early attention, it was considered more appropriate for study and resolution outside the context of this study.

In general, the applied research problem arises because NIH, the agency whose primary mission is research, has often been unresponsive to other program needs for this research. The solution lies either in devising ways to make this research responsive while leaving it in its present research setting or to place the research activities in the respective program settings where it can be responsive. The former alternative appeared more attractive because the direction and setting of research priorities, including applied research, is considered an appropriate and a necessary activity for the Assistant Secretary for Health.

5. The regional health director should be the top health official in the region and report to the office of the Assistant Secretary for Health

The major future responsibilities of the regional office (RO) health staff will be to help administer and monitor national health insurance activities, provide surveillance of the health delivery system, and assist in resource development and public health activities at the State and local level. The overall mission includes the following major functions.

Standards Compliance.—This will be a major activity in the administration of Medicare and Medicaid and in future national health insurance and revenue sharing programs. Standard setting and compliance activities relating to health provider participation influences the manner in which those services are organized and delivered. This function must be conducted in close cooperation with the designated State and local agencies.

Surveillance.—Regional Offices will play an important role in the health intelligence network. Information on health care needs, conditions, and program effectiveness must be gathered and analyzed on a State and regional basis to monitor programs and problems; to predict trends; to assess resource utilization; and to provide the basis for developing strategies for change in health financing and resource development programs.

Resource Development.—As an outgrowth of surveillance and assessment activities, the RO should target technical assistance and demonstration support to States and communities and provide means for channeling new health services knowledge and new developments in science and technology as a result of research.

Technical assistance activities should utilize capacities available within the RO's within the five central agencies, and elsewhere in the Department, as well as in other specialized resources throughout the nation. Technical assistance resources must be enhanced and expanded as appropriate. Support of this type will need to be provided to community groups and agencies, as well as health institutions and official agencies.

Preventive and Public Health Activities.—The Department's health activities have traditionally been especially concerned with helping the development of

State and local public health services. This focus should continue through the RO's, although it should be developed in a context of concern for a total health strategy. Effective assistance in this area will require a clearer definition of preventive health activities that should be focused on problems of disease control through epidemiology and immunization.

Given the stated mission of the regional health staff and the related functions, the recommendations on the RO's are:

The Regional Health Director (RHD) should be the principal health official in the RO. This role should include a broad mandate encompassing program leadership, planning, implementation and direction of day-to-day operations. It also should include a relationship with the Regional Director as principal health advisor, making unnecessary the position of Associate Regional Director for Health. The RHD should be responsible for all health programs in his region.

The RHD's should report to the Assistant Secretary for Health through the Deputy Assistant Secretary for Program Operations.

The capacity of RO staff to provide technical assistance should be increased as appropriate.

Grant decentralization should be completed promptly.

The RHD should develop mechanisms for the full integration of the efforts of the regional health staff such as consolidated work plans; consolidated operating budget for salaries and expenses; and flexibility in utilization of personnel.

IV. NEXT STEPS

Several factors need to be considered carefully in the development of an implementation strategy:

There is presently a high degree of momentum associated with the new leadership in DHEW which could be supportive of reorganization.

New agency heads will be designated in the near future. Reorganization activities should begin as soon as possible to avoid territorial disputes that may develop with delayed action.

The overall impact of the new health leadership to effect the proposed organizational changes will diminish with prolonged delay.

The current uncertainty and restlessness that permeates HSMHA demands immediate action and strong leadership.

The abolishment of HSMHA and creation of two new agencies (Health Services Administration and Health Resources Administration) could be done internally under the direction of an acting Administrator of HSMHA. The outward appearance of this approach, however, could well be construed as procrastination, with no intention of carrying out the reorganization. The need to avoid prolonged organizational chaos would argue strongly for an immediate break of HSMHA into HRA and HSA, with each agency reporting directly to OASH.

Since all of the recommended actions can be effected within the authority of the Secretary, concurrence in the overall concept at that level will be sufficient to begin implementation under the leadership and direction of the Assistant Secretary for Health.

The development and approval of a complete organizational plan containing detailed mission and function statements for all units is a time-consuming process. Effective reorganization will be seriously jeopardized if this process must be completed before implementation begins.

Immediate implementation will require management flexibility for making operating decisions within the overall framework of the recommended plan.

Details of the organizational structure can be developed as implementation proceeds.

Considering these factors, it is recommended that implementation proceed under the leadership of a management team assembled by the Assistant Secretary for Health. The team should include:

Deputy Assistant Secretary for Administration and Management.
Deputy Assistant Secretary for Medical and Scientific Affairs.
Deputy Assistant Secretary for Program Operations.
Administrator of HSA.
Administrator of HRA.
Director of NIH.
Director of CDC.

A nucleous of three or four managers that can direct day-to-day activities in specific areas of the reorganization.

There are two principal issues regarding the makeup of the management team. The first involves the integration of BHI and MSA and their ultimate transfer to HSA. The responsibility for this merger could be assigned to the Administrator of HSA along with the realignment of the service programs from HSMHA. Because of the magnitude of both tasks, the Assistant Secretary could elect to retain in his office the BHI/MSA responsibility until such time as the administrative details are finalized, thereby ensuring an orderly integration of these programs into HSA.

The second issue involves the agency heads' direct participation in this undertaking. Effective implementation will require a close working relationship that might not otherwise occur if each agency is left on its own to implement respective portions of the recommendations. It is quite important, therefore, that the entire team be held accountable for the reorganization.

The following steps should be taken to implement the reorganization:

Step 1.—Obtain Secretary and Under Secretary concurrence in overall concept. With this concurrence, delegate implementation authority and responsibility to the Assistant Secretary for Health.

Step 2.—Brief appropriate Congressional and Executive Offices. It is essential that these briefings be completed before details of the reorganization become general knowledge.

Step 3.—Appoint the management team and develop an implementation strategy and plan.

Step 4.—Transfer NIMH to NIH and initiate further study of its internal organizational and programmatic inter-relationships.

Step 5.—Establish CDC as an agency and transfer BCEM and NIOSH.

Step 6.—Establish two new agencies (HRA and HSA) and abolish HSMHA.

Step 7.—Transfer BHME from NIH to HRA.

Step 8.—Establish Regional Office liaison staff under the Deputy Assistant Secretary for Program Operations and begin to implement other recommendations relating to the Regional Offices.

Step 9.—On a predetermined date to be established by the Secretary, preferably not later than July 1, 1973, transfer BHI (SSA) and MSA (SRS) to the direction of the Assistant Secretary for Health. Within 90 days of this action, the OASH and the management of BHI and MSA will determine and implement the necessary administrative actions to integrate appropriate functions and establish their staffs in HSA.

If implementation is undertaken immediately along the general steps outlined above, the reorganization could reasonably be completed by October 1, 1973.

Time is of the essence and the degree of success will in large measure depend upon the speed with which implementation can proceed in an orderly manner. To this end, an early commitment from the Secretary is imperative.

Appendix A

Persons Interviewed During Study of HSMHA Programs and Organization

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Acting Administrator: David J. Sencer.

Deputy, Associate and Assistant Administrators:

- Frederick L. Stone, Interim Deputy Administrator and Acting Deputy Administrator for Development.
- Beverlee A. Myers, Associate Administrator for Program Planning and Evaluation.
- John H. Kelso, Associate Administrator for Management.
- David W. Johnson, Associate Administrator for Regional Offices.
- Gerald N. Kurtz, Associate Administrator for Communications and Public Affairs.
- Joan F. Bushnell, Assistant Administrator for Legislation.
- Robert J. Laur, Deputy Administrator for Prevention and Consumer Services.
- Emery A. Johnson, Acting Deputy Administrator for Health Services Delivery.
- Bertram S. Brown, Deputy Administrator for Mental Health.

Program Directors and Staff:

- David J. Sencer, Center for Disease Control.
- Marcus M. Key, National Institute for Occupational Safety and Health.
- Robert E. Novick, Bureau of Community Environmental Management.

Marjorie A. Costa, National Center for Family Planning Services; Albert B. Lauderbaugh.
Arthur J. Lesser, Maternal and Child Health Service; Grace M. Angle and Ralph R. Pardee.
Paul B. Batalden, Community Health Service; Michael J. Goran.
Emery A. Johnson, Indian Health Service.
Robert E. Streicher, Federal Health Programs Service; Roland D. McRae.
H. McDonald Rimple, National Health Service Corps; Howard G. Hilton and Alexander Montgomery.
Robert van Hoek, National Center for Health Services, Research, and Development.
Harald M. Graning, Health Care Facilities Service; Ruth E. Dunham.
Robert P. Janes, Comprehensive Health Planning Service; John Caponiti, Jr.
Harold Margulies, Regional Medical Programs Service.
Gordon K. MacLeod, Health Maintenance Organization Service.
Bertram S. Brown, National Institute of Mental Health; James D. Isbister and James D. Lawrence.
Morris E. Chafetz, National Institute on Alcohol Abuse and Alcoholism; Kenneth L. Eaton and John A. Deering.
William E. Bunney, Division of Narcotic Addiction and Drug Abuse; Karst Besteman.
Theodore D. Woolsey, National Center for Health Statistics; Edward B. Perrin.

Regional Health Directors:
Gertrude T. Hunter, Region I.
C. Robert Dean (Acting), Region II.
George C. Gardiner, Region III.
Eddie J. Sessions (Acting), Region IV.
E. Frank Ellis, Region V.
Holman E. Wherritt, Region VII.
Abel G. Ossorio, Region VIII.
Donald P. MacDonald (Deputy), Region IX.
David W. Johnson, Region X.

Other HSMHA Staff:
Eugene W. Veverka and Alvin E. Harvel, Office of the Associate Administrator for Regional Offices.
Donald E. Goldstone, Office of the Associate Administrator for Program Planning and Evaluation.

OTHER AGENCIES, HEW

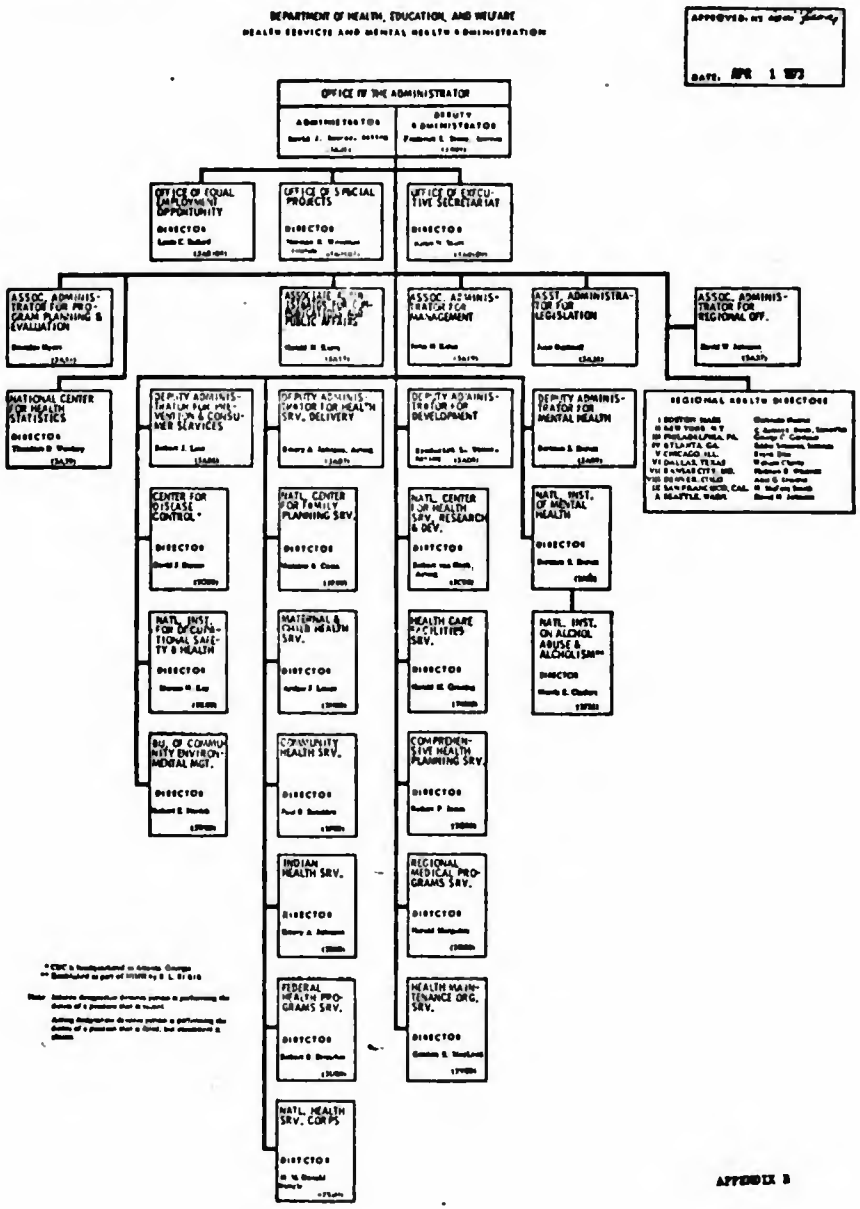
Morris R. Carnmer, Director, National Center for Toxicological Research, Food and Drug Administration.
Joseph P. Hile, Director, Executive Director of Regional Operations, FDA; Ronald T. Ottes.
John F. Sherman, Acting Director, National Institutes of Health; Robert Berliner, Thomas J. Kennedy, Leonard D. Fenninger and Leon Schwartz.
Kenneth M. Endicott, Director, Bureau of Health Manpower Education, NIH; Daniel F. Whiteside and Charles H. Boettner.
Calvin B. Baldwin, Jr., Executive Officer, National Cancer Institute, NIH; John C. Bailar, III and John W. Yarbro.
Theodore Cooper, Director, National Heart and Lung Institute, NIH.
David P. Rall, Director, National Institute of Environmental Health Services, NIH.
William W. Payne, Deputy Director, National Institute of Environmental Health Services, NIH, and Scientific Coordinator of Frederick Cancer Research Center.
Howard N. Newman, Commissioner, Medical Services Administration, Social and Rehabilitation Services.
Thomas M. Tierney, Director, Bureau of Health Insurance, Social Security Administration; Irwin Wolkstein and Morris B. Levy.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH, HEW

Richard L. Seggel, Deputy Assistant Secretary for Program Operations.
Scott Fleming, Deputy Assistant Secretary for Policy Development.
Wade H. Coleman, Special Assistant for Drug Abuse Prevention.
Rupert F. Moure, Acting Deputy Assistant Secretary for Administration and Management.

OFFICE OF THE SECRETARY, HEW

Bernard F. Kelly, Office of the Under Secretary.
Eugene Rubel, Executive Secretariat (Health).
Peter B. Hutt, Office of the General Counsel.
Keith Weikel, Office of the Assistant Secretary for Planning and Evaluation.
Peter Fox, Office of the Assistant Secretary for Planning and Evaluation.
Thomas S. McFee, Office of the Assistant Secretary for Administration and Management.
John Pinney, Office of the Assistant Secretary for Administration and Management.



Appendix C

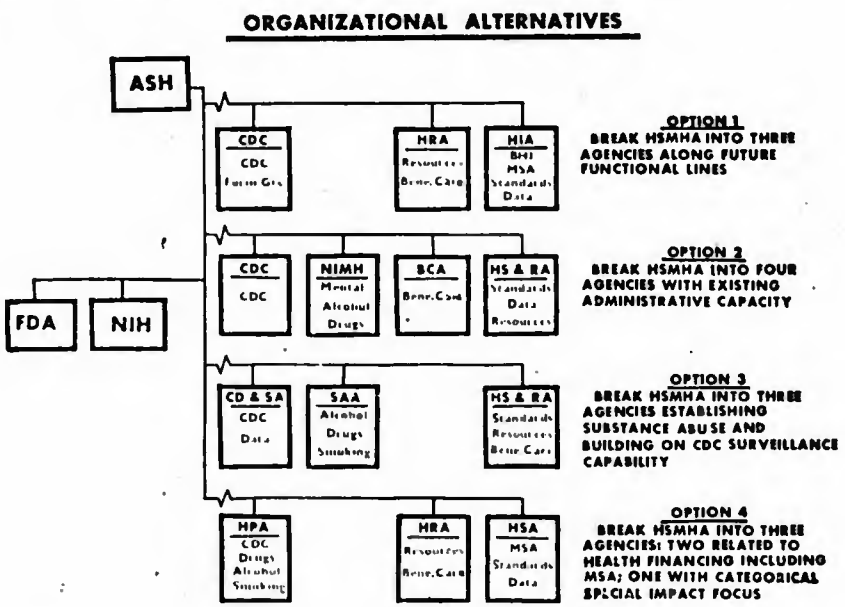
Analysis of Organizational Alternatives

Once the broad federal roles in health were defined, a common problem throughout the major issues as described was that the current organizational structure was inconsistent with these roles and therefore inhibited carrying them out. Four organizational options were developed which had as their core the need for an organizational framework based on an articulated federal health mission. The particular options were developed to isolate issues and contrast alternative ways of addressing them organizationally. They were not intended as "either-or" proposals since there are innumerable variations and combinations possible.

A review of the current activities of the various health components of HEW suggested that there were major health program functions—health services, prevention of health problems, and development of health resources. The organizational options were attempts to "package" various groupings of these program functions into agencies with coherent missions. In addition, the options reflected a pragmatic concern for the impact of any organizational change in ongoing operations in terms of the need to minimize the negative aspects of disruption and to maximize the use of existing administrative capabilities.

1. Description of Organizational Alternatives

For each alternative creating a new agency, a descriptive organizational title, abbreviated mission statement, and major functions were identified. These four alternatives are shown in chart form on the following page.



Option 1

Center for Disease Control

Mission.—Provide national leadership for the prevention and control of communicable disease and other public health functions.

Major Functions.—Develop means to prevent and control communicable diseases; stimulate State and community action through surveillance and education; provide technical assistance and demonstration of effective techniques for control of communicable diseases; enforce foreign quarantine regulations; administer State formula grant programs for drug abuse, alcoholism, public and mental health services, and maternal and child health; and develop standards to assure safe and healthful working environment.

Current organizational elements include the Center for Disease Control, the National Institute for Occupational Safety and Health, and all formula grant programs.

Health Resources Administration

Mission.—Prepare existing federally-assisted health services and manpower programs for financing through national health insurance or other appropriate sources.

Major Functions.—Provide management and technical assistance to existing health service programs for meeting financing program standards for reimbursement; continue to provide or arrange for health services to specific federal beneficiaries while facilitating conversion of these activities to support through financing programs; provide student and institutional assistance for the education of manpower to meet special problems which are not effectively covered under general educational support mechanisms; and support demonstrations designed to improve the future production and utilization of health services manpower.

HRA includes all HSMHA demonstration, service, and training project grant programs exclusive of those in CDC; direct care programs; the Bureau of Health Manpower Education exclusive of research and manpower intelligence activities; and the Nursing Home Improvement activities.

Health Insurance Administration

Mission.—Administer present Title XVIII (Medicare) and Title XIX (Medicaid) programs, including development, implementation and enforcement of standards, policies and procedures for participation in financing programs; provide HEW focus for the development and implementation of national health insurance; and conduct programs for monitoring, evaluating, and testing new approaches relating to health insurance programs.

Major Functions.—Administer Title XVIII and XIX programs; develop standards and certify providers for participation in financing programs; monitor compliance and adequacy of standards; evaluate overall impact of standards and financing for policy implications; review appropriateness of care received in terms of cost, quality and effectiveness; develop and test new approaches to improve the health insurance programs, including financing, delivery systems, and health manpower; collect data on health status and health services resources; analyze data for policy implications and disseminate information to appropriate action agencies.

HIA includes the health financing and related support activities in the Social Security Administration and the Social and Rehabilitation Service; HSMHA activities in medical care standards, research and development, comprehensive health planning, and health statistics; research and manpower intelligence from BHME; and the Professional Standards Review Organization from OASH.

OPTION 2

Center for Disease Control

Mission.—Provide national leadership for the prevention and control of communicable diseases.

Major Functions.—Develop means to prevent and control communicable diseases; stimulate State and community action through surveillance and education; provide technical assistance and demonstration of effective techniques for control of communicable diseases; enforce foreign quarantine regulations; and develop standards to assure a safe and healthful working environment.

The CDC includes the present Center for Disease Control and the National Institute for Occupational Safety and Health.

National Institute of Mental Health

Mission.—Provide national leadership in the field of mental health, including intensive efforts directed at such problems as alcoholism and drug abuse.

Major Functions.—Conduct and support research, training, and community programs in the areas of general mental health, drug abuse, and alcoholism; provide focus for collection and dissemination of information on drug abuse and alcoholism and other mental health problems; serve as principal focus for behavioral science activities and for cultural and social problems related to mental health.

The NIMH includes the current NIMH activities except for St. Elizabeths Hospital.

Beneficiary Care Administration

Mission.—Provide or arrange for health care for Federal beneficiary populations.

Major Functions.—Make arrangements for or provide health srevices to specified federal beneficiaries; facilitate the conversion of beneficiary care programs to financing through national health insurance or other mechanisms.

BCA includes the Indian Health Service, Federal Health Programs Service, and St. Elizabeths Hospital.

Health Standards and Resources Administration

Mission.—Facilitate development and implementation of health insurance programs through setting and monitoring of standards for participation in insurance programs; surveillance of health status and system resources; and preparing existing federally-assisted health services and manpower programs for financing through national health insurance or other appropriate sources.

Major Functions.—Develop standards and certify providers for participation in financing programs; monitor compliance and adequacy of standards; review appropriateness of care received in terms of cost, quality and effectiveness; evaluate overall impact of standards and financing for policy implications; develop and test new approaches to improve the health insurance programs, including financing, delivery systems, and health manpower; collect data on health status and health services resources; analyze data for policy implications and disseminate information to appropriate action agencies; provide management and technical assistance to existing health service programs for meeting financing program standards for reimbursement; provide student and institutional assistance for the education of manpower to meet special problems which are not effectively covered under general educational support mechnaisms; and support demonstrations designed to improve the future production and utilization of health services manpower.

The HSRA includes the Bureau of Health Manpower Education; HSMHA demonstration, service and training project and formula grant programs exclusive of those in NIMH and CDC; HSMHA medical care standards, comprehensive health planning and health statistics activities; and the Professional Standards Review Organization and Nursing Home Affairs activities from OASH.

OPTION 3

Communicable Disease and Surveillance Administration

Mission.—Monitor the health status and health delivery capacity of the nation and provide assistance to meet communicable disease and manpower shortage problems.

Major Functions.—Conduct data gathering, monitoring or epidemiological surveillance of health status and of health delivery resources; communicate findings to appropriate action agencies; analyze data for policy implications; control communicable diseases through stimulating action by State Health Departments or selectivc federal intervention; provide health personnel to critical shortage areas; and develop standards to assure safe and healthful working environment.

CDSA includes the HSMHA components of Center for Disease Control (exclusive of Smoking and Health), National Center for Health Statistics, National Institute for Occupational Safety and Health, and National Health Service Corps; and the manpower intelligence activities from BHME.

Substance Abuse Administration

Mission.—Provide assistance for the prevention and control of substance abuse.

Major Functions.—Develop the means to prevent, control and treat abuse of substances such as alcohol, drugs, and tobacco; provide training support for health workers in substance abuse; assist States and communities in dealing with these problems through public education, technical assistance and grant assistance to provide for treatment, rehabilitation and other community action programs.

The SSA includes the National Institute for Alcohol Abuse, the Drug Abuse Program, and Smoking and Health activities.

Health Standards and Resources Administration

Mission.—Facilitate development and implementation of health insurance programs through setting and monitoring of standards for participation in insurance programs; and preparing existing federally-assisted health services and manpower programs for financing through national health insurance or other appropriate sources.

Major Functions.—Develop standards and certify providers for participation in financing programs; monitor compliance and adequacy of standards; review appropriateness of care received in terms of cost, quality, and effectiveness; evaluate overall impact of standards and financing for policy implications; develop and test new approaches to improve the health insurance programs, including financing, delivery systems, and health manpower; provide management and technical assistance to existing health service programs for meeting financing program standards for reimbursement; provide student and institutional assistance for the education of manpower to meet special problems that are not effectively covered under general educational support mechanisms; support demonstrations designed to improve the future production and utilization of health services manpower; and continue to provide or arrange for health services to specific federal beneficiaries while facilitating conversion of these activities to support through financing programs.

The HSRA includes the Bureau of Health Manpower Education excluding manpower intelligence; all HSMHA demonstration, service, and training project and formula grants exclusive of those related to alcohol, durg abuse, and CDC; direct beneficiary care programs including St. Elizabeths Hospital; HSMHA activities in medical care standards; comprehensive health planning, and research and development; and Professional Standards Review Organization and Nursing Home Affairs activities from OASH.

OPTION 4

Health Protection Administration

Mission.—Provide national leadership for protection from public health hazards.

Major Functions.—Develop the means to prevent, control, and treat diseases and other health problems that pose a threat to public health through infection or safety hazards, such as communicable diseases, alcoholism, drug abuse, smoking, and unsafe working environments; stimulate State and community action to deal with these problems through surveillance, public awareness and education; and direct federal action to provide technical assistance and demonstrate effective techniques.

HPA includes the Center for Disease Control, alcohol and drug abuse activities, and the National Institute for Occupational Safety and Health.

Health Resources Administration

Mission.—Prepare existing federally-assisted health services and manpower programs for financing through national health insurance or other appropriate sources.

Major Functions.—Provide management and technical assistance to existing health service programs for meeting financing program standards for reimbursement; continue to provide or arrange for health services to specific federal beneficiaries while facilitating conversion of these activities to support through financing programs; provide student and institutional assistance for the education of manpower to meet special problems which are not effectively covered under general educational support mechanisms; and support demonstrations designed to improve the future production and utilization of health services manpower.

The HRA includes HSMHA demonstration, service, and training project and formula grant programs exclusive of alcohol, drug abuse and CDC; direct care programs including St. Elizabeths Hospital; the Bureau of Health Manpower Education exclusive of research and manpower intelligence; and the Nursing Home Improvement activities.

Health Standards Administration

Mission.—Provide professional health guidance for administration of financing programs; administer present Title XIX (Medicaid) Program; facilitate development and implementation of health insurance programs through surveillance of

health status and system resources; and set and monitor standards for participation in insurance programs.

Major Functions.—Develop standards and certify providers for participation in financing programs; administer Title XIX Program; monitor compliance and adequacy of standards; evaluate the overall impact of standards and financing for policy implications; review appropriateness of care received in terms of cost, quality, and effectiveness; develop and test new approaches to improve the health insurance programs, including financing, delivery system, and health manpower; collect data on health status of disease and health services resources; analyze data for policy implications and disseminate information to appropriate action agencies.

HSA includes the Medical Services Administration and related support activities in the Social and Rehabilitation Service; HSMHA medical care standards, comprehensive health planning, health statistics, and research and development; research and manpower intelligence activities from BHME; and the PSRO activities from OASH.

2. EVALUATION OF ORGANIZATIONAL ALTERNATIVES

The alternatives were evaluated against six criteria which addressed the study findings, as well as the practical considerations of implementing a new organizational alinement. The ranking of the alternatives within each criteria is shown in the following chart and is discussed in detail below.

EFFECTIVENESS OF OPTIONS IN MEETING ORGANIZATIONAL CRITERIA

Criteria	Option 1	Option 2	Option 3	Option 4
Facilitates development of integrated health policy for a national health mission.	Most	Least	Less	More.
Facilitates interprogram coordination within a single agency mission	do	do	do	Do.
Provides flexibility for future change	do	do	do	Do.
Facilitates regional operations	do	do	do	Do.
Facilitates implementation by building on existing administrative strengths.	do	Most	do	Least.
Minimizes disruption of ongoing activities	Least	do	More	Less.

How well does the organization facilitate development and implementation of integrated health policy and strategy for a national health mission? This criterion reflects the adequacy of the sum of the agency missions to comprise a total health mission as well as the degree to which organizational placement of activities supports development of national health policy.

a. Option 1—most effective. This alternative brings together all HEW health programs under single health leadership. All activities related to the financing of health care, the most extensive health program, would be consolidated in a single agency (HIA) along with the policy supporting activities of surveillance and health services research. In addition, the two other agencies (HRA and CDC) most clearly represent the other principal health roles of preventive and public health activities and resources support. The consolidation of activities supporting health care resources will facilitate their redirection toward a more effective relationship to the financing system.

b. Option 4—more effective. This alternative retains the advantage of providing an agency focus for health care financing activities (HSA) and resources (HRA). The financing role, however, is diminished with the absence of the largest financing program, Medicare, from HSA. In addition, the HPA focus is closer to problem-solving than prevention, and does not represent an articulated national health mission.

c. Option 3—less effective. The absence of either MSA or BHI further undermines the capacity to address the integration of federal health care financing activities. The existing health agency activities related to standard setting and monitoring are consolidated in HSRA, but their effectiveness would be diminished because of the additional responsibility to administer ongoing resources and direct care programs. The policy support focus is diminished with the separation of surveillance activities in CDSA from health services research in HSRA. The narrow focus of SAA does not reflect a broad federal mission, as do the other agencies.

d. Option 2—least effective. This alternative does not provide for consolidating the operating health care financing programs, and diminishes the focus of HSRA on policy support related to these programs. In addition, the resources activities

supporting the improved delivery of services are spread across three agencies, namely HSRA, BCA, and NIMH. The latter two agencies do not represent articulated national health missions.

How well does the organization facilitate interprogram coordination within a single agency mission? This criterion reflects the importance of a clear mission for each agency that unifies programs within the agency and facilitates coordination in achieving overall health policy.

a. Option 1—most effective. Under this alternative, each agency would be responsible for a single and distinct health mission. Functions relevant to achieving those missions are contained within each agency. Considerable coordination will be needed between the direct support for health services contained in the HRA with the health care financing agency (HIA). This coordination, however, is not required because of duplicative activities, but to implement overall federal policy in moving from direct to financing support.

b. Option 4—more effective. This alternative contains many of the advantages of the above option, but the functions within the HPA are not entirely consistent—i.e. alcohol and drug abuse treatment programs are not as closely related to other preventive activities as they are to the service activities in HRA. The coordination of all resources activities in facilitating their conversion to support through the financing system will thus be more complex.

c. Option 3—less effective. As with option 4 above, the coordination of ongoing service resources activities is made more complex by housing them in two separate agencies. In addition, two agencies lack a unifying mission and contain divergent functions. CDSA would be responsible for broad health care surveillance and the control of communicable diseases, and the HRSA would be responsible for supporting policy development in health care financing and the administration of health services resources programs.

d. Option 2—least effective. Resources activities would be distributed across three agencies (NIMH, BCA and HSRA) greatly complicating their coordination and consistent transition to support through the financing systems. Two of the agencies (HSRA and NIMH) contain several duplicative functions relevant to federal health missions.

How well does the organization provide flexibility for future change? This criterion reflects the ability of the organizational structure to accommodate changes which may be reasonably predicted at this point in time, without drastic realignment.

a. Option 1—most effective. This alternative proposes the greatest realignment now of the health programs into agencies that serve future functions. Changes could be accommodated easily within the agencies because their missions are broad yet distinct.

b. Option 4—more effective. This alternative contains many of the advantages of option 1 above, but is weakened by the addition of the time-limited direct Federal activities in alcoholism and drug abuse to the CDC, and creation of a new health protection agency whose focus will have to be changed as alcohol and drug abuse activities are phased out.

c. Option 3—less effective. This alternative would create a new agency for substance abuse to house the time-limited activities in alcoholism and drug abuse. As these activities are phased-out, the entire agency would probably be abolished, since its focus is too narrow to accommodate future change. In addition, this agency sets the precedent for establishment and dissolution of entire agencies in response to changing federal priorities for special action in specific problem areas.

d. Option 2—least effective. Two agencies, namely the NIMH and the BCA will require future realignment since they have a specific, categorical focus and contain time-limited activities.

How well does the organization facilitate regional operations? Based on the preliminary findings of this study related to regional office operations, it is assumed that regional offices activities will be integrated and focused on: 1) certification and monitoring of health care financing standards; 2) data gathering and surveillance; 3) developing resources for improved health care delivery; and 4) strengthening the States' public health capacities. This criterion addresses the amount of coordination that will be required of regional staff in implementing t e policy and programmatic direction of the national health agencies.

a. Option 1—most effective. Each regional activity is clearly aligned to one central agency function, requiring the least coordination at the regional level.

b. Option 4—more effective. Regional offices must coordinate policies from 2 agencies in resources development activities (HPA and HRA) and in health care financing activities (SSA and HSA).

c. Option 3—less effective. Regional resource activities will have to coordinate policies from two agencies (SAA and HSRA). Regional standards activities must coordinate policies from 3 agencies (HSRA, SRS and SSA).

d. Option 2—least effective. Regional resource activities must coordinate policies from three agencies (NIMH, BCA, and HSRA) and regional standards activities must coordinate policies from 3 agencies (HSRA, SSA and SRS).

How effectively will the organization facilitate implementation by building on existing administrative strengths?

a. Option 2—most effective. Three of the agencies, namely CDC, NIMH and BCA have substantial independent administrative capacity within them now, and the fourth, HSRA, can be readily created building on the administrative capacity of HSMHA.

b. Option 1—more effective. One new agency (HRA) would be created without any existing administrative support capacity. CDC is relatively self-sufficient and HIA would pick up administrative capacity with the transfer of BHI and MSA. In addition, legislation would be required to separate alcohol and drug abuse activities from NIMH.

c. Option 3—less effective. One agency (SAA) would be created without any existing administrative support capacity, and one (CDC) would require additional administrative staff to assume responsibility for all surveillance activities in support of health policy planning. Legislation would be required to separate alcohol and drug abuse activities from NIMH.

d. Option 4—least effective. Two new agencies would be created without existing administrative support capacities, namely HRA and HSA. This option would also require legislation to separate the drug and alcohol abuse programs from NIMH.

How effectively can the organization be implemented without disrupting ongoing activities?

a. Option 2—most effective. Under this alternative, all existing programs are maintained essentially intact.

b. Option 3—more effective. The NIMH and BHME programs would be split, with activities assigned to separate agencies. Data gathering activities and drug abuse and alcoholism activities would have to be realigned from their current organizations.

c. Option 4—less effective. This option is identical to option 3, in addition to which it would require the transfer of MSA from SRS.

d. Option 1—least effective. This alternative would be the most disruptive since it would distribute the activities of numerous current health services and health manpower programs to several different agencies in order to separate formula from project grant support in resources development; and would separate data gathering and surveillance as well as health services research activities from ongoing grant and contract support. In addition, it would require the transfer of both MSA and BHI from their current parent agencies.

3. NEED FOR A COMBINED APPROACH

As the preceding analysis demonstrates, there are disadvantages inherent in each of the four organizational options that were developed. While the first option, for instance, appears preferable according to most of the criteria, it would be the most disruptive to implement.

In addition, any of the options containing a separate health resources agency and a health insurance agency have two inherent problems. They would require considerable policy coordination between the service resource programs and the financing policy development activities in order to facilitate the conversion of service delivery activities to support through financing mechanisms other than grants. The health resources agency would place all current resource activities that are scheduled for termination or conversion to other forms of support in an agency that would retain no articulated long-term responsibility for health resources. Although many of the present grant-supported service delivery activities and the resource development activities are scheduled to be severely curtailed or redirected, there will be a continuing need for a capability to address the status of health care resources in the U.S. in order to provide responsive leadership and develop effective federal policies, including those related to the financing system.

Upon reexamining the options, it appeared desirable to combine the strong features of the four options, and to redefine the role with respect to health resources. The organizational recommendation, therefore, represents a combination and a reshaping of elements from the four options as they were originally developed.

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